

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
04652						CERTIFICATE OF DEATH						04651			
1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN 1b 1 hr 10 min d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SUBURBAN HOSPITAL						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 SILVER SPRING d. STREET ADDRESS 8403 DIXON AVE APT 2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) LAST ALEX, MIDDLE PETER, FIRST ANGELO						4. DATE OF DEATH Month 4 Day 8 Year 1962									
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/18/81		9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 8 Days 1		IF UNDER 24 HRS. Hours 1 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager-Retired						10b. KIND OF BUSINESS OR INDUSTRY Theater Business						11. BIRTHPLACE (County & State, or foreign country) Kamari, Greece		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Peter Alex						14. MOTHER'S MAIDEN NAME Mary TRIANTIFFILOU						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			
16. SOCIAL SECURITY NO. NONE						17. INFORMANT Helen A. Saridakis						Address 10702 Wooddale Dr. Silver Spring, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 155.0 GASTRO-INTESTINAL HEMORRAGE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTATIC CANCER (c) HEPATOMA PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): -												INTERVAL BETWEEN ONSET AND DEATH < 24 HRS > 9 MONTHS AT LEAST 9 MONTHS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from DEC. 19, 1961 , to APRIL 8, 1962 that (I) (we) last saw the deceased alive on APRIL 8, 1962 , and that death occurred at 5⁰⁰ P M, from the causes and on the date stated above.															
22a. SIGNATURE James A. Roberts M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED APRIL 8, 1962							
22c. PHYSICIAN'S NAME (Type) JAMES A. ROBERTS M.D.						22d. ADDRESS 8907 GEO. AVE. SILVER SPRING, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-11-62		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery				23d. LOCATION (City, town or county) (State) Rockville Montgomery Co, Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Fisher 34 Georgia Ave Warner E. Pumphrey, Inc. Silver Spring, Maryland						25a. REC'D BY REGISTRAR APR 12 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Hanna							

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WINTER 1941
JANUARY 1941
FEBRUARY 1941
MARCH 1941
APRIL 1941
MAY 1941
JUNE 1941
JULY 1941
AUGUST 1941
SEPTEMBER 1941
OCTOBER 1941
NOVEMBER 1941
DECEMBER 1941

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FEBRUARY 1942
MARCH 1942
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MAY 1942
JUNE 1942
JULY 1942
AUGUST 1942
SEPTEMBER 1942
OCTOBER 1942
NOVEMBER 1942
DECEMBER 1942

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JANUARY 1943
FEBRUARY 1943
MARCH 1943
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04654

04653

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 17 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 83x3 d. STREET ADDRESS 1625 S. Stafford Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frank Ervin Altizer		4. DATE OF DEATH Month Day Year April 30, 1962	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4-9-22
9. AGE (In years last birthday) 40 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Harvey Altizer		14. MOTHER'S MAIDEN NAME Lavinie I. Altizer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes 1942-1944		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 393.2 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Septicemia (c) Staph infection Mastoiditis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that 10 (this hospital) attended the deceased from April 13, 1962 to April 30, 1962 , that XX we last saw the deceased alive on April 30, 1962 and that death occurred at 10:55 AM from the causes and on the date stated above.			
22a. SIGNATURE Robert K. Middlekoff M.D.		22b. DATE SIGNED April 30, 1962	
22c. PHYSICIAN'S NAME (Type) ROBERT K. MIDDLEKOFF LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-3-62	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City, town or county) (State) Arlington, Virginia
24. FUNERAL DIRECTOR'S SIGNATURE Murphy Funeral Home		25a. REC'D BY REGISTRAR May 3 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04655		04654	
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville c. LENGTH OF STAY IN 1b MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS #7 South Adams Street	
3. NAME OF DECEASED (Type or print) Clarence Edward Anders		4. DATE OF DEATH April 8 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1890
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 3 Days 16	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles E Anders		14. MOTHER'S MAIDEN NAME Sarah Hahn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1	
17. INFORMANT Edna M. Anders-Wife-same 2d		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO (b) ARTERIAL HYPERTENSION DUE TO (c) GENERALIZED ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC RENAL FAILURE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (This hospital) attended the deceased from JAN. 1, 1956 to APRIL 8, 1962 that (I) (ye) last saw the deceased alive on APRIL 5, 1962 and that death occurred 6:50 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Gordon S. Rosenberger		22b. DATE SIGNED APRIL 8, 1962	
22c. PHYSICIAN'S NAME (Type) Gordon S. Rosenberger		22d. ADDRESS 310 West Montgomery Ave. Rockville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/11/62	
23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town or county) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25. REC'D BY REGISTRAR APR 13 '62	
25b. REGISTRAR'S SIGNATURE Carlton S. Hanna			

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25b. REGISTRAR'S SIGNATURE

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04658

04657

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 40 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27 Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2317 Michigan Ave</u>		d. STREET ADDRESS <u>2317 Mich. Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Frank Askins</u>		4. DATE OF DEATH <u>Apr 11 1962</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-15-1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	11. BIRTHPLACE (State or foreign country) <u>md</u>
13. FATHER'S NAME <u>Elliott Askins</u>		14. MOTHER'S MAIDEN NAME <u>Agnes</u> unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Agnes A. Russell</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> 4-11-62 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Chronic myocarditis</u> (c) <u>Arteriosclerotic vascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr</u> <u>month</u> <u>yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Agnes A. Russell</u> Address <u>1304 Gallatin St. Wash. D.C.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/14/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial.</u>		22d. LOCATION (City, town, or country) (State) <u>Sandy Spring, Md.</u>	
23. FUNERAL DIRECTOR <u>Robert L. Suroder</u>		24a. REC'D BY REGISTRAR <u>APR 23 '62</u>	
ADDRESS <u>Rockville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Robert L. Suroder</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04658

04658

1. PLACE OF DEATH

a. COUNTY

MONTGOMERY

MARYLAND

b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)

BETHESDA

c. LENGTH OF STAY (In hrs.)

3 Hrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

SUBURBAN Hospital

3. NAME OF DECEASED (Type or print)

Silas B

5. SEX

MALE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Attorney

10b. KIND OF BUSINESS OR INDUSTRY

Law

13. FATHER'S NAME

Lucian V. AXTELL

8. DATE OF BIRTH

3/30/85

9. AGE (In years last birthday)

77 yrs.

11. BIRTHPLACE (County & State, or foreign country)

Perry, Ohio

12. CITIZEN OF WHAT COUNTRY?

USA

14. MOTHER'S MAIDEN NAME

Josephine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

wife - Elizabeth M. AXTELL

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

CORONARY OCCLUSION

4200 DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

ARTERIOSCLEROTIC HEART DISEASE

DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Pulmonary Embolization

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Hour a.m. p.m. 19

20d. INJURY OCCURRED

While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21 I certify that (I) (this hospital) attended the deceased from APRIL 28, 1962 to APRIL 29, 1962 that (I) (we) last saw the deceased alive on APRIL 29, 1962 and that death occurred at 1:25 PM, from the causes and on the date stated above.

22a. SIGNATURE

Robert A. Angle

MD

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED

4/29/62

22c. PHYSICIAN'S NAME (Type)

ROBERT A. ANGLE

22d. ADDRESS

Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

Cremation

23b. DATE THEREOF

5/2/62

23c. NAME OF CEMETERY OR CREMATORY

Cedar Hill Crematory

23d. LOCATION (City, town or county)

Suitland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

Robert A. Pumphrey, Bethesda, Maryland

ADDRESS

25a. REC'D BY REGISTRAR

DATE 4 '62

25b. REGISTRAR'S SIGNATURE

Arthur S. Hume

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04661

04600

Item 23b Film 0311 1/26/62 mb

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 3 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania		b. COUNTY Philadelphia		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia		d. STREET ADDRESS 3048 N. 9th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Irene Margaret Baker		First Irene		Middle Margaret		Last Baker		4. DATE OF DEATH April 17, 1962		Month April		Day 17		Year 1962			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH November 5, 1906		9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 55		Days 55		IF UNDER 24 HRS. Hours 55			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Gundaker		14. MOTHER'S MAIDEN NAME Mary Gray		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 15-000000000		17. INFORMANT Mary Gray	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410X Cardiac tamponade DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. Rheumatic valvulitis, inactive, with mitral stenosis DUE TO PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 20 years		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hours		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (he) (this hospital) attended the deceased from April 14, 1962 to April 17, 1962 , that (he) (we) we saw the deceased alive on April 17, 1962 , and that death occurred at 1:00 PM from the causes and on the date stated above.		22a. SIGNATURE Lewis N. Cahill		22b. DATE SIGNED April 17, 1962		22c. PHYSICIAN'S NAME (Type) LEWIS N. CAHILL LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22f. REC'D BY REGISTRAR Robert A. Pumphrey		22g. REGISTRAR'S SIGNATURE Robert A. Pumphrey		22h. DATE APR 23 '62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 23, 1962		23c. NAME OF CEMETERY OR CREMATORY Beverley National		23d. LOCATION (City, town or county) Beverley, New Jersey		23e. STATE New Jersey		23f. ADDRESS Bethesda, Maryland		23g. NAME OF FUNERAL HOME Robert A. Pumphrey Funeral Home		23h. ADDRESS 7557 Wisc. Ave.		23i. CITY Bethesda, Maryland	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04662

04661

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 25 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 5406 McKinley Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) Jonathan J. Baker		4. DATE OF DEATH Month April Day 27 Year 1962		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 1, 1898		9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 63 Days 0 Hours 0 Min. 0		11. IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Maryland				11. BIRTHPLACE (County & State, or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Baker				14. MOTHER'S MAIDEN NAME Roslie Henderson				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 578-46-6800				17. INFORMANT David Baker			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO Myocardial Infarct Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerotic Heart Disease DUE TO 3 weeks 4 years				19. INTERVAL BETWEEN ONSET AND DEATH 3 weeks				20. PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) same as above				21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
22a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				23a. TIME OF INJURY Month, Day, Year 19				23b. INJURY OCCURRED While at work				23c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home			
24. I certify that (I) (th's hospital) attended the deceased from March 1959 to April 27, 1962 , that (I) (we) last saw the deceased alive on April 28, 1962 , and that death occurred at 5:20 P.M. from the causes and on the date stated above.				25a. SIGNATURE W. H. Killax				25b. DATE SIGNED APR 30 '62				26. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
27a. BURIAL, CREMATION, REMOVAL (Specify)				27b. DATE THEREOF 4/30/62				27c. NAME OF CEMETERY OR CREMATORY Rockville				27d. LOCATION (City, town or county) Rockville, Maryland							
28. FUNERAL DIRECTOR'S SIGNATURE W. H. Killax				28a. ADDRESS 1500 Rockville, Md.				28b. REC'D BY REGISTRAR APR 30 '62				28c. REGISTRAR'S SIGNATURE Arthur S. Hinkle							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04663

04662

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>1081 Ruatan Street</u>		d. STREET ADDRESS <u>1081 Ruatan Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Virgil</u> Middle <u>Lee</u> Last <u>Bankson</u>		4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 24, 1908</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Economist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Department</u>	
11. BIRTHPLACE (State or foreign country) <u>Park, Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles W. Bankson</u>		14. MOTHER'S MAIDEN NAME <u>Ella May Green</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) if yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Ross R. Bankson</u>		Address <u>1081 Ruatan St, Silver Spring, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma - Transverse Colon</u> DUE TO (b) <u>Uncertain</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Probably 5 or 6 mos.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/21, 1961</u> to <u>4/14, 1962</u> that (I) (we) last saw the deceased alive on <u>4/13, 1962</u> and that death occurred at <u>10 AM</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>A. B. Little</u>		22b. DATE <u>4/14/1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. B. LITTLE, MD</u>		22d. ADDRESS <u>6911 5th St, NW Washington, D.C.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-17-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Prince George's Co., Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Warner</u>		25a. REC'D BY REGISTRAR <u>APR 17 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur E. Kneer</u>		25c. ADDRESS <u>Warner E. Pumphrey, Inc. Silver Spring, Maryland</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death occurs at home, it may be executed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04664

04663

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>3 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>District of Columbia</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>478</u> d. STREET ADDRESS <u>105 Rittenhouse St. N.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William</u> <u>FRED</u> <u>BARNER</u>		4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 8, 1887</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>4</u> Hours <u>12</u> Min. <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard Retired U.S. Government</u>		12. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>	
13. FATHER'S NAME <u>Matthew Barner</u>		14. MOTHER'S MAIDEN NAME <u>MARY Stein</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-09-7857</u>	
17. INFORMANT <u>Washington Hospital Record</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Azotemia</u> Conditions, if any, which gave rise to immediate cause (b) <u>Nephrosclerosis</u> (a), stating the underlying cause last. (c) <u>Generalized arteriosclerosis & hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a) <u>Pleural effusion and pulmonary edema</u>	
19. INTERVAL BETWEEN ONSET OF DEATH <u>4 months</u> <u>5 yrs</u> <u>12 yrs</u>		20. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. TIME OF INJURY Month, Day, Year <u>19</u> <u>62</u> Hour a.m. <u>11:50</u> p.m. <u>00</u>		22. INJURY OCCURRED Whole <input type="checkbox"/> Not Whole <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		24. (City or town) (County) (State)	
25. I certify that (I) (this hospital) attended the deceased from <u>Dec 1961</u> to <u>April 1, 1962</u> and that (I) (we) last saw the deceased alive on <u>April 1, 1962</u> and that death occurred at <u>11:50 A.M.</u> from the causes and on the date stated above.			
26a. SIGNATURE <u>Samuel M. Bageant</u> M.D.		26b. DATE <u>4/2/62</u>	
26c. PHYSICIAN'S NAME (Type) <u>Samuel M. Bageant</u>		26d. ADDRESS <u>5600 New Hampshire Ave. N.E.</u>	
27a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		27b. DATE THEREOF <u>4/4/62</u>	
27c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem. Ft. Myer, Va.</u>		27d. LOCATION (City, town or county) (State)	
28. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hino Co. Washington 9, D.C.</u>		29. REC'D BY REGISTRAR <u>APR 5 '62</u>	
29. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>			



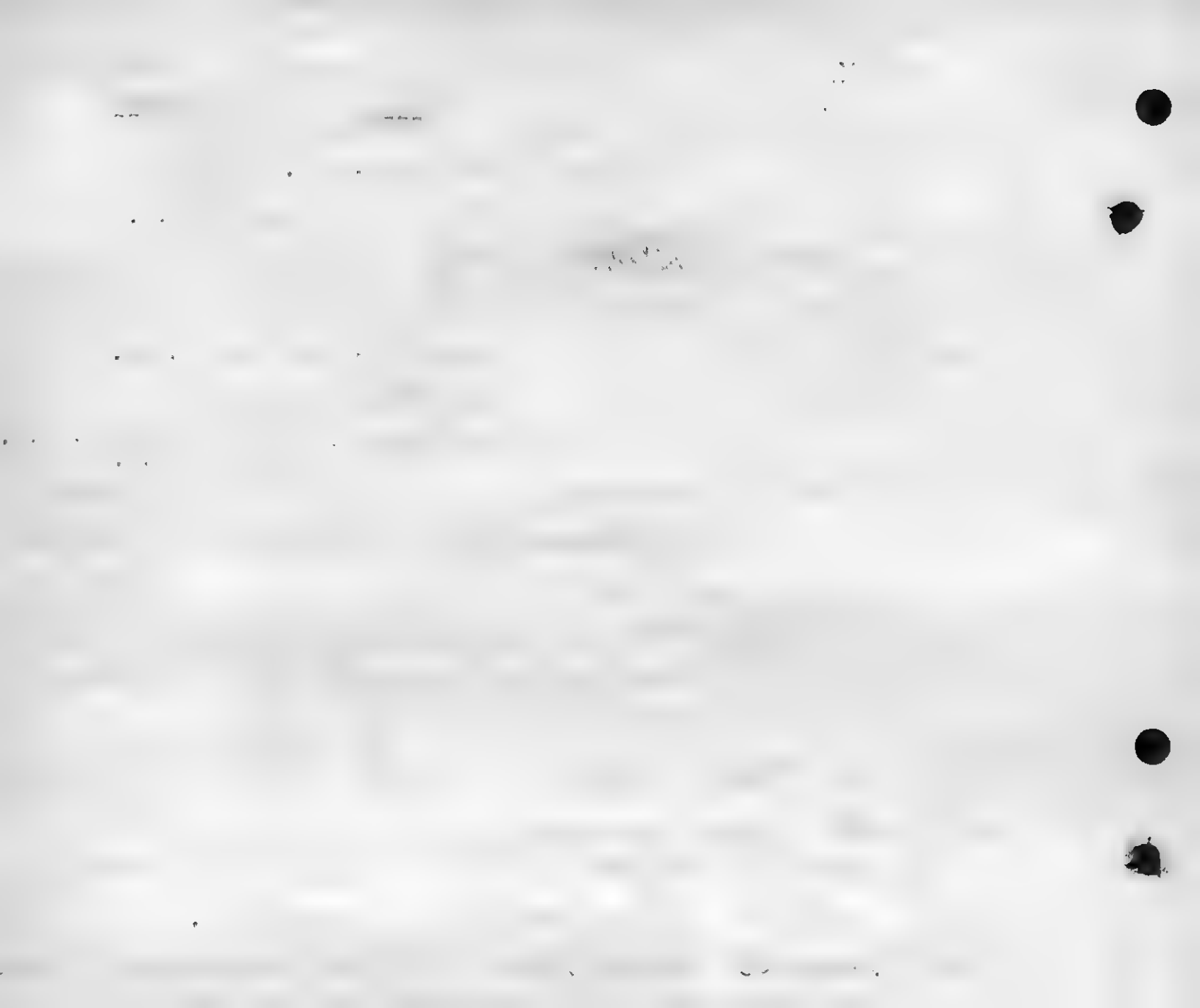
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

YR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04664

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN TB <u>2 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1000 Daleview Drive</u> <u>Althea Woodland Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington, D.C.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> d. STREET ADDRESS <u>4000 Cathedral Avenue, N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Catherine Barrett</u> First Last		4. DATE OF DEATH <u>April 10,</u> 19 <u>62</u> Month Day Year			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. AGE (in years last birthday) <u>90</u> yrs.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH <u>1/23/1872</u>		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Louisville, Kentucky</u>	
13. FATHER'S NAME <u>Thomas Barrett</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Flynn</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Florence Huebner</u> Address <u>4000 Cathedral Ave., N.W. Washington, D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> DUE TO <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic</u> DUE TO <u>Diabetes mellitus</u> (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>Secondary & Emphysema pulmonary</u> (b) <u>Arteriosclerosis</u> (c) <u>Arteriosclerosis</u>					
19. WAS A TOLPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>also Arteriosclerosis</u>		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> to <u>10 April 1962</u> that (I) (we) last saw the deceased alive on <u>8 April 1962</u> and that death occurred at <u>12:37 PM</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Harry A. Horstman, Jr.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10 April 62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Harry A. Horstman, Jr.</u>		22d. ADDRESS <u>915 - 19th St. NW Wash DC</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>4/11/1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	
23d. LOCATION (City, town or county) <u>Louisville, Kentucky</u>		23e. REC'D BY REGISTRAR <u>Arthur S. Thomas</u>		23f. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S. A. Miller Co</u>		24b. ADDRESS <u>2800 14th St. N.W. Wash DC</u>		24c. DATE <u>APR 12 '62</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04666

04665

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring,		c. LENGTH OF STAY IN b. 3 weeks		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 3028 Kingtree St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
3. NAME OF DECEASED (Type or print) Mary Louise Baumgartner		First		Middle		Last		4. DATE OF DEATH April 7 1962		Month		Day		Year																							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 13, 1873		9. AGE (In years last birthday) 88 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.																									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Stroy		14. MOTHER'S MAIDEN NAME Johanna Kupke		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Donald Kinsinger 10,620 Ga. Ave., Silver Spg. Md.																					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 12000 DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Congestive Heart Failure PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <input type="checkbox"/>		20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 10620 Georgia Ave., S.		20f. (City or town) Silver Spring, Md.		(County) Montgomery		(State) Md.																			
21. I certify that (I) (this hospital) attended the deceased from Feb 10, 1956 to April 7, 1962 that (I) (we) last saw the deceased alive on Mar 7, 1962 and that death occurred at 8 AM , from the causes and on the date stated above		22a. SIGNATURE John J. Curry		22b. DATE SIGNED 4/7/62		22c. PHYSICIAN'S NAME (Type) John J. Curry		22d. ADDRESS 10620 Georgia Ave., S.		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ATTENDING PHYS. <input checked="" type="checkbox"/>		22g. DATE SIGNED 4/7/62		22h. SIGNATURE William S. Thomas		22i. ADDRESS 10620 Georgia Ave., S.																			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Wed. Apr. 11, 1962		23c. NAME OF CEMETERY OR CREMATORY Trinity Evangelical		23d. LOCATION (City, town or county) Murdock, Nebr.		23e. STATE Nebr.		24. FUNERAL DIRECTOR'S SIGNATURE Raymond Q. Zaleski		24a. ADDRESS Silver Spring, Md.		24b. PHONE NO. 8434		24c. NAME WARNER E. PUMPHREY INC.		24d. ADDRESS 8434 Georgia Ave.,		24e. CITY Silver Spring, Md.		24f. STATE Md.		24g. ZIP CODE 20910		24h. DATE APR 11 '62		24i. SIGNATURE William S. Thomas		24j. ADDRESS 10620 Georgia Ave.,		24k. CITY Silver Spring, Md.		24l. STATE Md.		24m. ZIP CODE 20910	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed and filed in by the funeral director. After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04667
04666

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>D</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u> d. STREET ADDRESS <u>400 N. 2nd St. Lot 38</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MR. Walter Stanley BEALES</u>		4. DATE OF DEATH <u>April 19 1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-25-97</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Roberts Bros. Co.</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Robert Beales</u>		14. MOTHER'S MAIDEN NAME <u>Florence Mitchell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1572</u>	
17. INFORMATION <u>Patient's Chart</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage, bile nephrosis</u> DUE TO <u>1572</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, <u>Distention of common bile duct</u> DUE TO <u>Carcinoma of head of pancreas</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>3/23/1956</u> to <u>4/19/1962</u> that (I) (we) last saw the deceased alive on <u>4/19/1962</u> and that death occurred at <u>4/19/1962</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Arthur L. Frank</u>		22b. DATE SIGNED <u>4/19/62</u>	
22c. PHYSICIAN'S NAME (Type) <u> </u>		22d. ADDRESS <u>7030 Carver Lane Takoma Park, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/24/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town or county) <u>Arlington, Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Gasch's Sons</u>		25a. REC'D BY REGISTRAR <u>APR 24 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>		25c. ADDRESS <u>Hyattsville, Md.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be signed by the physician or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04668

04667

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47 Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7424 Exeter Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Agnes Middle W. T. Last Beall		4. DATE OF DEATH Month April Day 6 Year 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 29, 1869
9. AGE (In years last birthday) 92 yrs		10. IF UNDER 1 YEAR Months 8 Days 7 Hours Min 	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY -----	
11c. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John B. Thomas		14. MOTHER'S MAIDEN NAME Ann Emmert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT same 2d		Address Emmert Beall-son-Bethesda, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant-carcinoma 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF STOMACH DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 4 MONTHS 14 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from JULY 21, 1952 to APRIL , 19 62 that (I) (we) last saw the deceased alive on APRIL 6, 1962 and that death occurred at 1:40 AM , from the causes and on the date stated above.			
22a. SIGNATURE Robert G. Angle		22b. DATE 4/6/62	
22c. PHYSICIAN'S NAME (Type) Robert G. Angle		22d. ADDRESS Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/9/62	23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	23d. LOCATION (City, town, or county) (State) Washington, D. C.
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumfrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR APR 9 1962	
25b. REGISTRAR'S SIGNATURE Clifton E. Thomas			

1
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a medical director, please secure the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04669 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04668

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		d. STREET ADDRESS <u>5012 Cushing Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5012 Cushing Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Paul Lawrence Beck</u>		4. DATE OF DEATH <u>Apr 3 1962</u>		5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-6-1918</u>		9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>91-8-904</u>		11. BIRTHPLACE (State or foreign country) <u>Colorado</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fred Beck</u>				14. MOTHER'S MAIDEN NAME <u>Christina Lynn</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Edna Beck (wfe.)</u>		Address <u>Stuen 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage & laceration</u> DUE TO (b) <u>Bullet wound in left temple</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self inflicted bullet wound in left skull</u>					
20c. TIME OF INJURY Month, Day, Year <u>5:50 p.m. 4-3 1962</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Kensington</u> (County) <u>Montg</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4/6/62</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>				22d. LOCATION (City, town, or country) <u>Arlington, Virginia</u>			
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>APR 6 '62</u>			
				24b. REGISTRAR'S SIGNATURE <u>S. Thoma</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04670 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04669

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		
c. LENGTH OF STAY IN 1b <u>years</u>			d. STREET ADDRESS <u>7300 Birch Ave</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7300 Birch Ave</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Horace Wilson Bennett Jr.</u>			4. DATE OF DEATH <u>Apr 13 1962</u>		
5. SEX <u>male</u>			6. COLOR OR RACE <u>white</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>7-8-1907</u>		
9. AGE (In years last birthday) <u>54</u> yrs.			10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		
11. BIRTHPLACE (State or foreign country) <u>md</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>		
13. FATHER'S NAME <u>Horace W. Bennett</u>			14. MOTHER'S MAIDEN NAME <u>Columbia E. Richter</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>272-14-3120</u>		
17. INFORMANT <u>Mary Bennett (wife)</u>			Address <u>8807 Glenville Rd Silver Spring, md</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage & laceration</u> 476X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>shot gun wound thru skull</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>Self-inflicted shot gun wound - 20 gauge</u>					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted shot gun wound - 20 gauge</u>					
20c. TIME OF INJURY Month, Day, Year <u>11:00 a.m. 4-13 1962</u>					
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>					
20f. (City or town) (County) (State) <u>Takoma Park Montg md</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D. EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>4-13-62</u> Address (Street, city, town, or county) <u>254 Carroll St Wash. D.C.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					
22b. DATE THEREOF <u>April 16, 1962</u>					
22c. NAME OF CEMETERY OR CREMATORY <u>Neelsville Cemetery</u>					
22d. LOCATION (City, town, or country) (State) <u>near Germantown-Mont. Co. Maryland</u>					
24a. REC'D BY REGISTRAR DATE <u>APR 18 '62</u>					
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DEPARTMENT OF STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04671

04670

1. PLACE OF DEATH
a. COUNTY **Montgomery** **MARYLAND**
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Bethesda**
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **Resmor Sanitarium**

2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE **Virginia** b. COUNTY **Arlington**
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Arlington**
d. STREET ADDRESS **1135 South Thomas Street**
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
First **Lily** Middle **Ellen** Last **BENNING**
4. DATE OF DEATH **April 2 19 62**

5. SEX **Female** 6. COLOR OR RACE **White** 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH **Aug. 25, 1874** 9. AGE (In years last birthday) **87** yrs. IF UNDER 1 YEAR Months **7** Days **7** IF UNDER 24 HRS. Hours **7** Min. **7**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **None** 10b. KIND OF BUSINESS OR INDUSTRY **None** 11. BIRTHPLACE (County & State, or foreign country) **Canada** 12. CITIZEN OF WHAT COUNTRY? **Canada**

13. FATHER'S NAME **Nicholas P. Benning** 14. MOTHER'S MAIDEN NAME **Mary O'Brien**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) **No** 16. SOCIAL SECURITY NO **None** 17. INFORMANT **Albert Parks, Nephew** Address **Mary O'Brien**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Myocardial infarction**
DUE TO (b) **effusion previous myocardial infarction**
DUE TO (c) **Arteriosclerotic heart disease severe**
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a) **Diabetes Mellitus**

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. **19** p.m. 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from **March 22 1962** to **April 2 1962** that (I) (we) last saw the deceased alive on **April 2 1962** and that death occurred at **7:30 PM**, from the causes and on the date stated above

22a. SIGNATURE **George H. Mitchell** 22b. DATE SIGNED **April 3, 1962**
22c. PHYSICIAN'S NAME (Type) **George H. Mitchell** 22d. ADDRESS **10620 Georgia Ave, Silver Spring Md.**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial-Transit 4/5/62** 23b. DATE THEREOF **4/5/62** 23c. NAME OF CEMETERY OR CREMATORY **Paris Cemetery** 23d. LOCATION (City, town or county) (State) **Paris, Ontario Canada**

24. FUNERAL DIRECTOR'S SIGNATURE **Robert A. Pumphrey, Bethesda, Maryland** 25a. REC'D BY REGISTRAR **APR 6 '62** 25b. REGISTRAR'S SIGNATURE **Carlton S. Thomas**

TO DEPT. OF MEDICAL EXAMINERS: This certificate should be executed within 24 hours after death. If any delay is necessary, it may be executed by the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Box 39 - Laurel 1 (Rural)</u>	
c. LENGTH OF STAY IN lb <u>DOA.</u>		d. STREET ADDRESS <u>Greencastle Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montg. Gen. Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Edward Birch</u>	First Middle Last	4. DATE OF DEATH <u>Apr 6 1962</u>	Month Day Year
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2-4-62</u>
9. AGE (In years last birthday) <u>0 yrs.</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) <u>md</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Robert Birch</u>	14. MOTHER'S MAIDEN NAME <u>Dorothy Morris</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO. <u>2-4-62</u>	17. INFORMANT <u>Dorothy Birch (mother)</u>	Address <u>Stem 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>upper Respiratory Infection</u> DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Found collapsed in bed 3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of Item 18.]	
20c. TIME OF INJURY Hour <u>19</u> e.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschak</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHAK</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 7, 1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sanage Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Sanage Md</u>	
23. FUNERAL DIRECTOR <u>DeWitt Donaldson</u>		24a. REC'D BY REGISTRAR <u>APR 11 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		DATE	

TO DEPARTMENT OF MEDICAL CERTIFICATION: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04673 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04672

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>00 A</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. & Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mont</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>12412 Colston Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Raymond Benke Boyle</u> First Middle Last 4. DATE OF DEATH <u>Apr 3 1962</u> Month Day Year		5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>8-9-14</u> 9. AGE (In years last birthday) <u>47</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tourist guide</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Gray Lines</u> 11. BIRTHPLACE (State or foreign country) <u>Wash. D C</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Joseph Emery Boyle</u> 14. MOTHER'S MAIDEN NAME <u>Delia Finnegan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes, WW II</u> 16. SOCIAL SECURITY NO. <u>579-05-4543</u> 17. INFORMANT <u>MRS. Patricia B Boyle</u> Address <u>5500 Ken St Apt 2</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. _____ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II. of item 18) _____ 20c. TIME OF INJURY Hour a.m. p.m. _____ Mon h. Day. Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>4-3-62</u> Address (Street city town or county) _____	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>4-6-62</u> 22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u> 22d. LOCATION (City, town, or country) (State) <u>Forest Glen Montgomery Co, Maryland</u>		23. FUNERAL DIRECTOR <u>Raymond A. Ziska</u> Address <u>8434 Georgia Ave.</u> 24a. REC'D BY REGISTRAR <u>APR 6 '62</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04674

04673

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u> c. LENGTH OF STAY in 1b <u>7</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Forest Oak</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u> d. STREET ADDRESS <u>12 Park Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Cleveland</u> Last <u>Archer</u>		4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 28-1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired government clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>James H. W. Arches</u>		14. MOTHER'S MAIDEN NAME <u>Drusilla Snyder</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes give year or dates of service) <u></u>		17. INFORMANT <u>RS HAMIE A. Arches</u> Address <u>as 2 Beltsville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIAL HYPERTENSION</u> (c) <u>GENERALIZED ARTERIOSCLEROSIS</u> PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. City or town (County) (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 1956</u> to <u>April 18, 1962</u> that (I) (we) last saw the deceased alive on <u>March 10, 1962</u> and that death occurred at <u>10:45 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Forrest R. Rosenberg</u> M.D.		22b. DATE SIGNED <u>April 18, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Forrest R. Rosenberg</u>		22d. ADDRESS <u>310 W. Montgomery and Rockville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Apr 21-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>	23d. LOCATION (City, town or county) (State) <u>Beltsville, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Archer</u>		25e. REC'D BY REGISTRAR <u>APR 23 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles S. Miller</u>			

FOR STATE
HEALTH DEPT.

TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM
5M 9'60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04675

04674

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>10</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>Route 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bessie Lillian Bruce</u>		4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1962</u>		9. AGE (in years last birthday) <u>38</u> yrs.	
5. SEX <u>F</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. DATE OF BIRTH <u>August 15, 1923</u>	
13. FATHER'S NAME <u>James Black</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple injuries, extensive</u> DUE TO (c) <u>Auto accident</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b). 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was passenger in car involved in accident</u>			
20c. TIME OF INJURY Hour <u>4:35</u> p.m. Month, Day, Year <u>4-17 1962</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>U.S.R-29</u>	
20f. (City or town) <u>Spencerville Monty Md</u>		20g. (County) <u>Montgomery</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4-26-62</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or other disposition of body <u>Burial</u>		22b. DATE THEREOF <u>4/29/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Piney Hill Church.</u>	
				22d. LOCATION (City, town, or country) <u>Amherst, Va.</u>	
23. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>4/1 '62</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VE A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04676

CERTIFICATE OF DEATH

04675

Item d Film 3311

4/26/62 mh

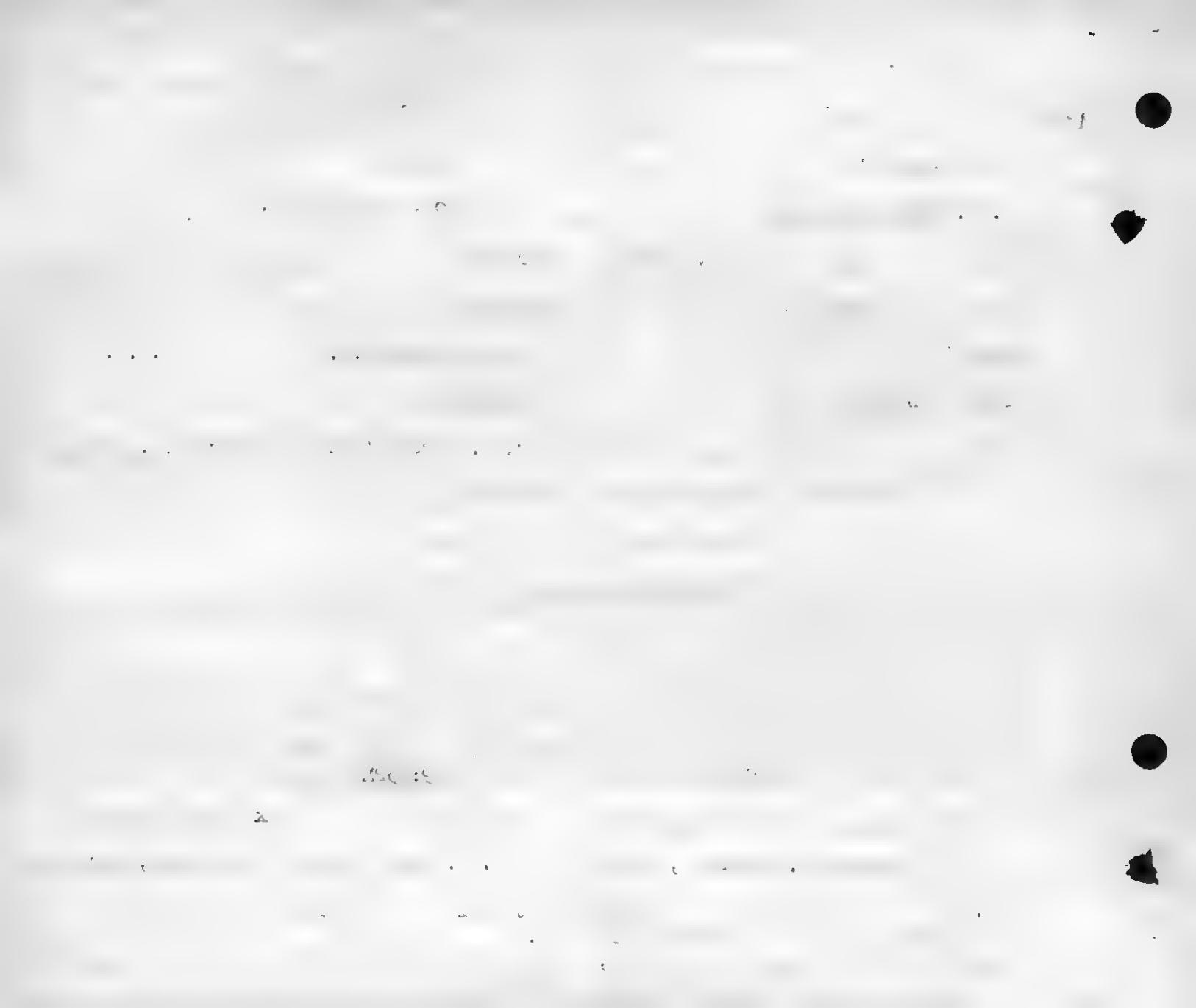
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 27 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Mont. Co. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 45 Bethesda d. STREET ADDRESS 5605- Sonoma Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna M. Brunssen First Middle Last 4. DATE OF DEATH April 16, 1962 Month Day Year		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 1877 Sept. 16, 1877 9. AGE (In years last birthday) 84 yrs. 10. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 11. BIRTHPLACE (Country & State, or foreign country) Germany 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Nickel 14. MOTHER'S MAIDEN NAME Elizabeth Einway 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. no 17. INFORMANT Margaret Whedon /s same as above Address _____		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (e) Broncho pneumonia (b) Congestive heart failure (c) Arteriosclerotic, hypertensive heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Rheumatoid arthritis, psoriasis 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from March 1955 to 4-16-1962 ; that (I) (we) last saw the deceased alive on 4-16-1962 , and that death occurred at 6:15 P.M. from the causes and on the date stated above. 22a. SIGNATURE Dorothy G. Gill 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) Dorothy G. Gill, M.D. 22d. ADDRESS 2511 Arlington Rd., Bethesda 14, Md. 22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 4/18/62 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery 23d. LOCATION (City, town or county) (State) Westchester Co. New York		24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey, Bethesda, Maryland 25. REC'D BY REGISTRAR APR 19 1962 25b. REGISTRAR'S SIGNATURE Arthur L. Kneass	



Item 238. 1118 0311 4/1/2007 iwk

MEDICAL CERTIFICATION

VR AFS (4)
15M 7/61



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The funeral director, or the funeral director, should be filled with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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04678
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C
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04677

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before adm.ssion) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Rural Etchison		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS 1	
3 NAME OF DECEASED (Type or print!) First Merson Middle - Last Burns		4. DATE OF DEATH Month April Day 20 Year 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 21, 1890
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joshia R. Burns		14. MOTHER'S MAIDEN NAME Alice V. Merson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO -	
17. INFORMANT Address Mrs. Merson Burns Rt. #2 Gaithersburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage, Embolus 17-2-01 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 2/16 19 52 to 4/20 19 62 that (I) was last saw the deceased alive on 4/19 19 62 , and that death occurred at 6:30 PM, from the causes and on the date stated above.			
22a. SIGNATURE James P. Kerr M.D.		22b. DATE 4/21/62	
22c. PHYSICIAN'S NAME (Type) James P. Kerr		22d. ADDRESS Damascus Md.	
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 4-23-62	
23c. NAME OF CEMETERY OR CREMATORY Laytonsville		23d. LOCATION (City, town, or county) (State) Laytonsville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber		25a. REC'D BY REGISTRAR APR 26 '62	
ADDRESS Laytonsville, Md.		25b. REGISTRAR'S SIGNATURE William L. Hanna	



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FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> d. STREET ADDRESS <u>29 W. Irving St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Raymond Hillery Burrows</u> First Middle Last 4. DATE OF DEATH <u>April 5, 1962</u> Month Day Year						5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>5/12/1889</u> 9. AGE (In years last b. birthday) <u>72</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Concrete const.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u> 11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						13. FATHER'S NAME <u>Robert Burrows</u> 14. MOTHER'S MAIDEN NAME <u>Harriet Powers</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> 16. SOCIAL SECURITY NO. <u>218-30-3857</u> 17. INFORMANT <u>Raymond R. Burrows</u> Address <u>10706 - Resnick Rd.</u> 18. CAUSE OF DEATH (Enter on separate lines for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary artery insufficiency</u> DUE TO <u>Severe coronary artery atherosclerosis</u> (b) <u>4 years</u> DUE TO <u>4 years</u> (c) <u>4 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Antero septal myocardial infarction, extensive, healed.</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Was driver of car which left highway</u> 20c. TIME OF INJURY Month, Day, Year <u>4-5-1962</u> Hour <u>3:15</u> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u> 20f. (City or town, County, State) <u>Bethesda Montgomery Md</u>						21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S SIGNATURE <u>Frank J. Broschatt</u> M.D. EXAMINER'S NAME (Type) <u>FRANK J. Broschatt</u> Address (Street, city, town, or county) <u>4-6-62</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>4/9/62</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u> 22d. LOCATION (City, town, or country) <u>Arlington, Virginia</u> (State)					
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u> ADDRESS						24a. REC'D BY REGISTRAR <u>APR 9 '62</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
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1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 41 days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia		b. COUNTY Lexington		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bluebridges, Rt. #4		d. STREET ADDRESS Bluebridges, Rt. #4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Charles William Anthony Campbell		First Charles		Middle William		Last Anthony		4. DATE OF DEATH April 3, 1962		Month April		Day 3		Year 1962									
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 16, 1883		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 7 Days 19		IF UNDER 24 HRS. Hours 18 Min. 19		12. CITIZEN OF WHAT COUNTRY? USA									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Naval Officer		10b. KIND OF BUSINESS OR INDUSTRY North Dakota		11. BIRTHPLACE (County & State, or foreign country) North Dakota		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles Campbell		14. MOTHER'S MAIDEN NAME Elizabeth T. Hughes		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes		16. SOCIAL SECURITY NO. Hospital Records									
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO ASHD Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) ASHD DUE TO Carcinoma, Prostate (c) Carcinoma, Prostate		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		18. INTERVAL BETWEEN ONSET AND DEATH 15 min. 10 yr. 2 weeks		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour 19 e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Arlington, Virginia		20g. (County) Arlington		20h. (State) Virginia	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 22, 1962 to April 3, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 3, 1962 , and that death occurred at 12:15 PM on the causes and on the date stated above.		22a. SIGNATURE H. S. IRONS		22b. DATE SIGNED April 4, 1962		22c. PHYSICIAN'S NAME (Type) H. S. IRONS LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		22e. REC'D BY REGISTRAR APR 6 '62		22f. REGISTRAR'S SIGNATURE Arthur L. Thomas		22g. DATE APR 6 '62		22h. REGISTRAR'S SIGNATURE Arthur L. Thomas							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-5-62		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) Arlington, Virginia		23e. ADDRESS Bethesda, Md.		23f. NAME OF CEMETERY OR CREMATORY Arlington National		23g. LOCATION (City, town or county) Arlington, Virginia		23h. ADDRESS Bethesda, Md.		23i. NAME OF CEMETERY OR CREMATORY Arlington National		23j. LOCATION (City, town or county) Arlington, Virginia		23k. ADDRESS Bethesda, Md.			
24a. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24b. NAME OF FUNERAL HOME Funeral Home, 7557 Wisc. Ave.		24c. ADDRESS Funeral Home, 7557 Wisc. Ave.		24d. CITY 7557 Wisc. Ave.		24e. STATE 7557 Wisc. Ave.		24f. ZIP CODE 7557 Wisc. Ave.		24g. PHONE NUMBER 7557 Wisc. Ave.		24h. FAX NUMBER 7557 Wisc. Ave.		24i. E-MAIL ADDRESS 7557 Wisc. Ave.		24j. WEBSITE 7557 Wisc. Ave.		24k. OTHER CONTACT INFORMATION 7557 Wisc. Ave.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be filled out by the attending physician or by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Silver Spring						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital					d. STREET ADDRESS 1 9226 Long Branch Parkway			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Herbert Middle Graham Last Campion					4. DATE OF DEATH Month April Day 19 Year 1962						
5 SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 23, 1905		9. AGE (In years last birthday) 56 yrs			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Administrative Clerk		10b. KIND OF BUSINESS OR INDUSTRY P.E.P.CO.		11. BIRTHPLACE (State or foreign country) Philadelphia, Pennsylvania			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Herbert G. Campion					14. MOTHER'S MAIDEN NAME Gale Tredrick						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If give prior or dates of service) 257 05 0637		17. INFORMANT Address Lora I. Campion 9226 Long Branch Pkwy. S.S., Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 152.1 Bronchogenic Carcinoma of lung with metastasis to brain Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 8-9 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 1962 4/18 to 1962 4/19 that (I) (we) last saw the deceased alive on 4/18 1962 and that death occurred at 10:45 AM , from the causes and on the date stated above.											
22a. SIGNATURE William D. Aud M.D.					ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22b. DATE SIGNED 4/20/62			
22c. PHYSICIAN'S NAME (Type) William D. Aud					22d. ADDRESS 9006 Colesville Rd, Silver Spring, Md.						
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 4-24-62		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery			23d. LOCATION (City, town, or county) (State) Arlington, Virginia				
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.					ADDRESS 8434 Georgia Ave		25a. REC'D BY REGISTRAR APR 23 1962		25b. REGISTRAR'S SIGNATURE Wm. S. Thomas		



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be completed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

C4682

CERTIFICATE OF DEATH

C4681

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY - N 1b 21 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission only) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Seat Pleasant d. STREET ADDRESS 7612 D Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ann Marie Carter		4. DATE OF DEATH April 17, 19 62	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 23, 1900	
9. AGE (in years last birthday) 61 yrs.		10. F UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		12. TDB. KIND OF BUSINESS OR INDUSTRY None	
13. FATHER'S NAME John Foran		14. MOTHER'S MAIDEN NAME Mary Hand	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unascertainable	
17. INFORMANT The Medical Records		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO 172 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Carcinoma of endometriuri DUE TO (c) 1 year	
19. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). 1		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour e.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 1 (this hospital) attended the deceased from March 27, 19 62 to April 17, 19 62 that 1 (we) last saw the deceased alive on April 17, 19 62 , and that death occurred at 5:45 AM , from the causes and on the date stated above.			
22a. SIGNATURE Richard S. Rivlin		22b. DATE SIGNED April 18, 1962	
22c. PHYSICIAN'S NAME (Type) Richard S. Rivlin, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF April 20, 1962	
23c. NAME OF CEMETERY OR CREMATORY Mt. Erin Cent.		23d. LOCATION (City, town or county) (State) Harve De Grose Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. W. Lee - Wash. D. C.		25a. REC'D BY REGISTRAR APR 23 '62	
25b. REGISTRAR'S SIGNATURE Charles E. Hines			

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04683

04682

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Germantown		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Germantown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 47		d. STREET ADDRESS Box 47	
3. NAME OF DECEASED (Type or print) First THERESA Middle LYNN Last CAVELL		4. DATE OF DEATH Month April Day 30 Year 1962	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 26 March 1962	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Frederick, Md.	
13. FATHER'S NAME Arthur L. Cavell		14. MOTHER'S MAIDEN NAME Charlotte Evelyn Nusbaum	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Arthur L. Cavell (Same as item #1)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492X DUE TO Virus pneumonia Conditions, if any, which gave rise to immediate cause (b) 492X (c), stating the underlying cause last. DUE TO 492X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (e) INTERVAL BETWEEN ONSET AND DEATH 4 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 1962 to 4-30-1962 , that (I) (we) last saw the deceased alive on 4-30-1962 , and that death occurred at 9:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Rex R. Martin, M. D.		22b. DATE SIGNED 1 May 1962	
22c. PHYSICIAN'S NAME (Type) Rex R. Martin, M. D.		22d. ADDRESS 220 N. Market St., Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-3-62	
23c. NAME OF CEMETERY OR CREMATORY Baptist Cemetery		23d. LOCATION (City, town or county) (State) Germantown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR DATE MAY 3 '62	
		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. It may be filed by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper and file with the State Dept. of Health.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04684

Item 8 Film G310 4/7/62 1wk

CERTIFICATE OF DEATH

04683

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SUBURBAN HOSP.</u>		d. STREET ADDRESS <u>3213 Wisconsin Ave. N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Norma</u> Middle <u>N.</u> Last <u>Chappell</u>		DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1962</u>	
5. SEX <u>Female</u>		9. AGE (In years if UNDER 1 YEAR; if UNDER 24 HRS. last birthday) <u>68</u> yrs. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>10/23/1893</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. Monroe Bradley</u>		14. MOTHER'S MAIDEN NAME <u>Martha Jordan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Chart</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (b) DUE TO <u>Rupture, heart, interventricular septum</u> (c) DUE TO <u>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>72 hours</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3-30-1962</u> to <u>4-2-1962</u> that (I) (we) last saw the deceased alive on <u>4-2-1962</u> and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Peter P. Andrews</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>4-2-62</u>			
22c. PHYSICIAN'S NAME (Type) <u>Peter P. Andrews</u> 22d. ADDRESS <u>4801 FESSENDEN ST N.W. D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4-4-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> 23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase General Home</u> ADDRESS <u>5101 Wisconsin Ave. N.W.</u> 25a. REC'D BY REGISTRAR <u>APR 8 '62</u> 25b. REGISTRAR'S SIGNATURE <u>William L. Thomas</u>			

1
FOR-STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Pages 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04685

04684

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
c. LENGTH OF STAY in 1b <u>2 1/2 yrs</u>				d. STREET ADDRESS <u>5734 Crawford Dr</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5734 Crawford Dr</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Agnes Ann Chirnack</u>				4. DATE OF DEATH <u>Apr 8 1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-17-01</u>	
9. AGE (in years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				11. BIRTHPLACE (State or foreign country) <u>Poland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Michael Dengos</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Schudlewsk</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or date of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Leona Von Bretzel</u>				Address <u>13509 Bailey Dr Rockville md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>C coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Due to</u> DUE TO (b) <u>Due to</u> DUE TO (c) <u>Due to</u>				INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.A. Left heart - 6 mo.</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a.m.</u> Month, Day, Year <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Apr 8 1962</u>			
Address (Street, city, town, or county)				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/11/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Silver Spring, Maryland</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24e. REC'D BY REGISTRAR <u>APR 13 '62</u>			
				24b. REGISTRAR'S SIGNATURE <u>C. Louis S. Evans</u>			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director, or your file. 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04685											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institutional; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg - RTU #3</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>						d. STREET ADDRESS <u>Watkins Mill Rd.</u>					
3. NAME OF DECEASED (Type or print) <u>David Wayne Claggett</u>						4. DATE OF DEATH <u>Apr 11 1962</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-20-61</u>		9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR: Months <u>1</u> Days <u>11</u> Hours <u>1</u> Min. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>md</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>RONALD CLAGGETT</u>				14. MOTHER'S MAIDEN NAME <u>MARY CAMPBELL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>INFORMANT</u>				17. Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u>											
DUE TO (b) <u>Inhalation of smoke</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Home fire at home</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2nd + 3rd degree burn involving chest upper ext. of face</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>house fire at home</u>											
20c. TIME OF INJURY Month, Day, Year <u>1:30 p.m. 4-11-1962</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
20f. (City or town) <u>Gaithersburg</u>				(County) <u>Monty</u>				(State) <u>md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
DATE SIGNED <u>4-11-62</u>											
ACTUAL SIGNATURE <u>Frank J. Broschark</u> EXAMINER'S NAME (Type) <u>FRANK J. Broschark</u>											
Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4-14-62</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Broke Grove</u>			
22d. LOCATION (city, town, or county) <u>Daytonville, N.C.</u>				(State) <u>md</u>				24a. REC'D BY REGISTRAR <u>APR 19 '62</u>			
24b. REGISTRAR'S SIGNATURE <u>Robert L. Suwender</u>											
23. FUNERAL DIRECTOR ADDRESS <u>Robert L. Suwender - Rockville Md</u>											

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/6D

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04687 CERTIFICATE OF DEATH 04686

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in lb <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>Tampa</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>5013 - 28th Street</u> d. STREET ADDRESS <u>5013 - 28th Street</u>	
3. NAME OF DECEASED (Type or print) <u>Linia Marie Clark</u>		4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1962</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>24 February 1954</u>	
9. AGE (In years, last birthday) <u>8</u> yrs.		10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Kelly</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Clark</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>The Medical Record</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO <u>204</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>204</u> (b) <u>Bronchopneumonia -- Cardiac Failure</u> DUE TO <u>204</u> (c) <u>Acute Lymphocytic Leukemia</u>	
19. INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u>		20. INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
22a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		22b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
22c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22d. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 5, 1962</u> , to <u>April 9, 1962</u> , that (I) (we) last saw the deceased alive on <u>April 9, 1962</u> , and that death occurred at <u>7:15 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert H. Levir</u> M.D.		22b. DATE SIGNED <u>April 9, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert H. Levir, M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>April 19, 1962</u>		23b. DATE THEREOF <u>April 19, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Travis's Funeral Home, 384-R.S. Ave. N.W.</u>		23d. LOCATION (City, town or county) (State) <u>Tampa, Florida</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Travis's Funeral Home, 384-R.S. Ave. N.W.</u>		25a. REC'D BY REGISTRAR <u>APR 12 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Walter S. Hanna</u>		25c. REGISTRAR'S SIGNATURE <u>Walter S. Hanna</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div> <div> <div>1-1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>04688</div> </div> <div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>04687</div> </div> </div>																							
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SANITARIUM + Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, MD.</u> d. STREET ADDRESS <u>410 Philadelphia Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) <u>Grace Winner Close</u>		4. DATE OF DEATH <u>April 18</u> 19 <u>62</u>		5. SEX <u>fe</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 28, 1898</u>													
9. AGE (In years last birthday) <u>63</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Mins.</td> </tr> <tr> <td><u>11</u></td> <td><u>21</u></td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Mins.	<u>11</u>	<u>21</u>			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Artist Illustrator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Andrew Jackson Albertson Winner</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.																					
Months	Days	Hours	Mins.																				
<u>11</u>	<u>21</u>																						
14. MOTHER'S MAIDEN NAME <u>Annie Kate Roller</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>pts. son</u>		16. SOCIAL SECURITY NO. <u>HORACE W. CLOSE</u>		17. INFORMANT <u>Same as above.</u>		18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> (b) <u>4-20-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>autopsy</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. a.																							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part I of item 18)																					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE <u>Frank J. Broschaw</u>		EXAMINER'S NAME (Type) <u>FRANK J. Broschaw</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>4-18-62</u>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/21/1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL MEMORIAL PARK</u>		22d. LOCATION (City, town, or country) <u>FALLS CHURCH VIRGINIA</u>		24a. REC'D BY REGISTRAR <u>APR 23 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>													
23. FUNERAL DIRECTOR <u>Martins W. Kram Company</u>		ADDRESS <u>1300-N. Street, N.W.</u>		DATE <u>Wash 5, D.C.</u>																			

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04689

CERTIFICATE OF DEATH

04688

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b <u>102 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>North Dakota</u> b. COUNTY <u>1</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fargo</u> d. STREET ADDRESS <u>1223 S. Tenth Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ray</u> First <u>Harold</u> Middle <u>Coffman</u> Last		4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>19 62</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 27, 1918</u>	
9. AGE (In years last birthday) <u>43</u> yrs. IF UNDER 1 YEAR Months <u>7</u> Days <u>13</u> IF UNDER 24 HRS. Hours <u>13</u> M n.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreign Service Officer</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Kansas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Harold Coffman</u>	
14. MOTHER'S MAIDEN NAME <u>Aletha Marrow</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Unknown</u>	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Hospital Records</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> (b) <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>18</u> (this hospital) attended the deceased from <u>December 26, 1961</u> , to <u>April 7, 1962</u> , that <u>18</u> (we) last saw the deceased alive on <u>April 7, 1962</u> , and that death occurred <u>7:30 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Vern N. Houk</u>		22b. DATE SIGNED <u>April 8, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Vern N. Houk LCDR MC USN</u>		22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>4-10-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Lee's Sons Co. Funeral Home 4th & Mass. Ave., Wash. D.C.</u>		25. REC'D BY REGISTRAR <u>APR 12 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. **64689**

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE FLORIDA b. COUNTY DADE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIAMI	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11807-PITSON ROAD		d. STREET ADDRESS 657-5.W. 11th ST	
3. NAME OF DECEASED (Type or print) First ABRAHAM Middle I. Last COHEN		4. DATE OF DEATH Month APRIL Day 26 Year 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR-24-1898
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHYSICIAN (RET)		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) N.Y. CITY		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME MORRIS COHEN		14. MOTHER'S MAIDEN NAME SARAH SILVERSTEIN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT DR. RICHARD COHEN		Address SSB.MD. 12028 CLARIDGE B.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arteriosclerosis DUE TO (c) Generalized Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 1 day 20 years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 15 1961 to April 26 1962 that I last saw the deceased alive on April 26 1962 , and that death occurred at 2 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John J. Curry M.D.		ADDRESS (Street, city or town, state) 10620 Georgetown Silver Spring	
PHYSICIAN'S NAME (Type)		DATE SIGNED 4/26/62	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 4/27/62	
22c. NAME OF CEMETERY OR CREMATORY KIRSCHENBAUM BROS.		22d. LOCATION (City, town, or county) (State) BROOKLYN, N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE Quelberg Funeral Home		ADDRESS 4217-9th ST NW	
24a. REC'D BY REGISTRAR APR 30 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04691

CERTIFICATE OF DEATH

04690

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda (Rural)

c. LENGTH OF STAY IN 1b

32 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

Maryland

b. COUNTY

Anne Arundel

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Woodland Beach

d. STREET ADDRESS

12X2
• IS RESIDENCE ON A FARM?
YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)

First

William

Middle

Thomas

Last

Conway

4. DATE OF DEATH

Month

Day

Year

April 11,

1962

5. SEX

Male

6. COLOR OR RACE

Caucasian

7. MARRIED ☐ NEVER MARRIED ☐

8. DATE OF BIRTH

Sept. 29, 1884

9. AGE (In years last birthday)

77 yrs.

IF UNDER 1 YEAR, Months Days

IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Service Man

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Joseph Conway

14. MOTHER'S MAIDEN NAME

Mary Murray

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

Yes ☒ No ☐ Unknown ☐

WW II

16. SOCIAL SECURITY NO.

Hospital Records

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Bronchopneumonia.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Thrombosis in distribution right middle cerebral artery

DUE TO

Arteriosclerosis.

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

INTERVAL BETWEEN ONSET AND DEATH

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)

20c. TIME OF INJURY
Hour a.m. p.m.

Month, Day, Year
19

20d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that ~~XXX~~ (this hospital) attended the deceased from March 9, ..., 1962 to April 11, 1962 that (I) (we) last saw the deceased alive on... April 11, 1962, and that death occurred at 2:55 AM on the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

JOHN R. WARMOLTS LT MC USN

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS.

22d. ADDRESS

U. S. Naval Hospital, Bethesda, Md.

22b. DATE SIGNED

April 11, 1963

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

April 14, 1962

23c. NAME OF CEMETERY OR CREMATORY

New St. Mary's Cemetery

23d. LOCATION (City, town or county)

Bellmawr,

New Jersey

24. FUNERAL DIRECTOR'S SIGNATURE

Benjamin Hopping

Address

Annapolis, Md.

25a. REC'D BY REGISTRAR

DATE PR 16 '62

25b. REGISTRAR'S SIGNATURE

Charles L. Finner

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

04692

04691

1. PLACE OF DEATH
a. COUNTY **MONTGOMERY** **MARYLAND**
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **BETHESDA (RURAL.)**
c. LENGTH OF STAY IN 1b **27 days**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **U.S. NAVAL HOSPITAL, BETHESDA, MD.**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE **VIRGINIA**
b. COUNTY **ARLINGTON**
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **83x 2**
d. STREET ADDRESS **5626 5th ST. S. ARLINGTON**
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) **Virginia Dellinger COPE**
4. DATE OF DEATH **APRIL 26 1962**
5. SEX **Female** 6. COLOR OR RACE **Cauc.** 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH **3-16-87**
9. AGE (In years last birthday) **75** yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housewife** 10b. KIND OF BUSINESS OR INDUSTRY **MINN.** 11. BIRTHPLACE (County & State or foreign country) **USA** 12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME **Daniel N. DELLINGER** 14. MOTHER'S MAIDEN NAME **Clara C. HELFRICH**
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **NO** 16. SOCIAL SECURITY NO. **Unknown** 17. INFORMANT **(D) Consuelo Cope TAYLOR** Address **Same as #2 above**
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Metastatic carcinoma of Breast**
170X } (b) DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (c) DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) **Pneumonia Heart Disease with Aortic Insufficiency**
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of statement)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from **3-31**, 1962, to **4-26**, 1962, that (X) (we) last saw the deceased alive on **4-26**, 1962, and that death occurred at **9:35 AM** on the causes and on the date stated above.
22a. SIGNATURE **P.G. LINAWEAVER** 22b. DATE SIGNED **4-26-62**
22c. PHYSICIAN'S NAME (Type) **P.G. LINAWEAVER** 22d. ADDRESS **U.S. NAVAL HOSPITAL, BETHESDA, MARYLAND**
23a. BURIAL, CREMATION, REMOVAL (Specify) **BURIAL** 23b. DATE THEREOF **4-30-62** 23c. NAME OF CEMETERY OR CREMATORY **ARLINGTON NATIONAL** 23d. LOCATION (City, town or county) **ARLINGTON, VIRGINIA** (State)
24. FUNERAL DIRECTOR'S SIGNATURE **ROBERT MURPHY** 25a. REC'D BY REGISTRAR **APR 30 '62** 25b. REGISTRAR'S SIGNATURE **Arthur L. Hanks**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, and 4 may be completed by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled out by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04692

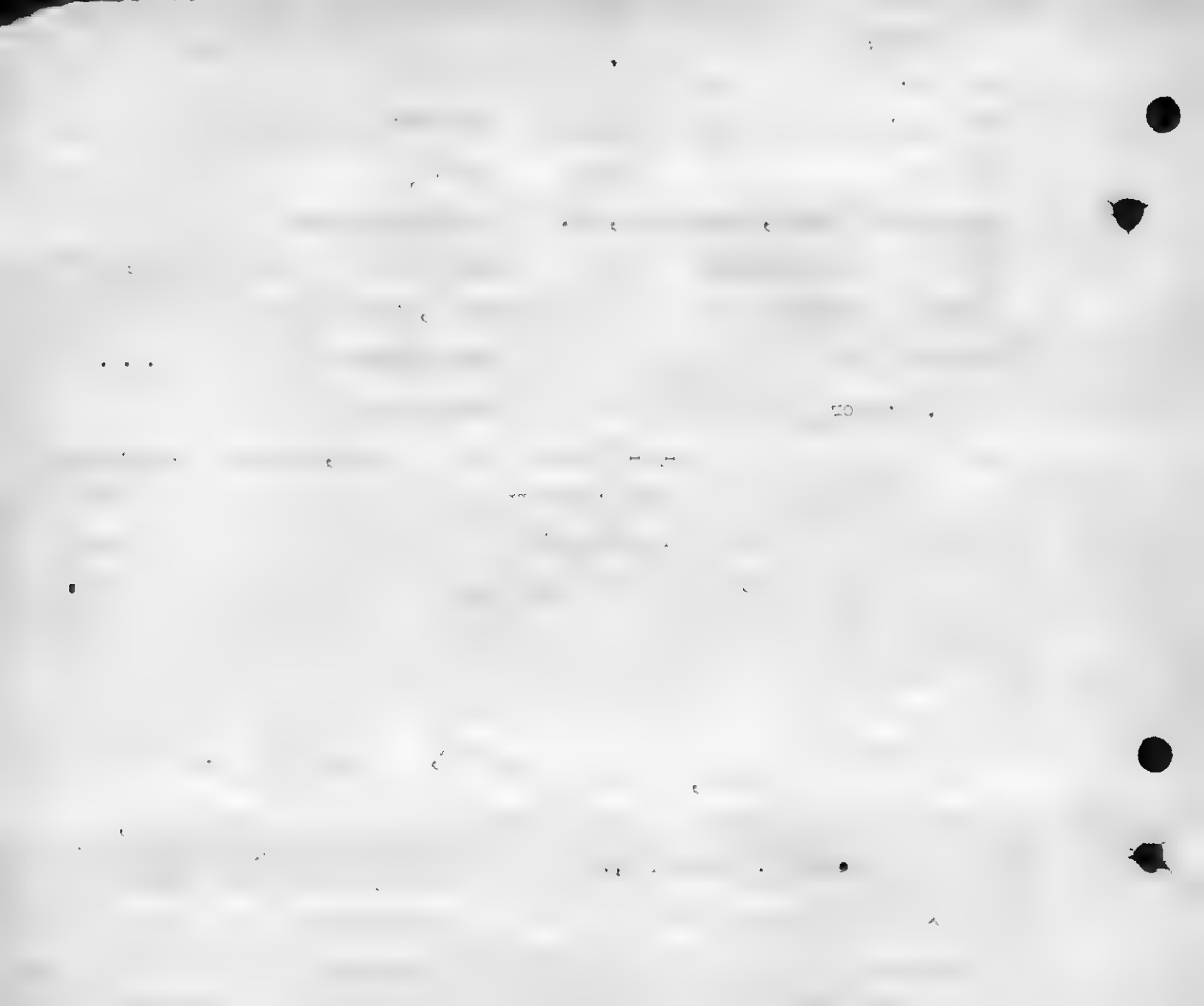
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5802 OSCEOLA RD</u>		e. STREET ADDRESS <u>15802 OSCEOLA RD</u>	
3. NAME OF DECEASED (Type or print) <u>CATHERINE</u> First <u>ANN</u> Middle <u>COX</u> Last		4. DATE OF DEATH <u>APRIL</u> Month <u>15</u> Day <u>19</u> Year <u>1962</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-4-1940</u>
9. AGE (In years last birthday) <u>22</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>DASHINGTON DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EDWARD SUMNER COX</u>		14. MOTHER'S MAIDEN NAME <u>LAURA ADELS SMITH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>EDWARD S COX</u> Address <u>5802 OSCEOLA RD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u> </u> DUE TO <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1944</u> to <u>April 1962</u> that I last saw the deceased alive on <u>April 1962</u> and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>35 W. 14th St. N.W.</u> DATE SIGNED <u>4/1/62</u> ACTUAL SIGNATURE <u>J. K. Hester</u> M.D. <u>35 W. 14th St. N.W.</u> PHYSICIAN'S NAME (Type) <u>CHESTER BRADY MD</u> <u>35 W. 14th St. N.W.</u> <u>4-1-62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>4-4-62</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>		22d. LOCATION (City, town, or county) (State) <u>WILFORD, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Haulon</u> ADDRESS <u>4748 Wisc</u>		24a. REC'D BY REGISTRAR DATE <u>APR 9 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Christy S. Thomas</u>			

TO HOSEBORN OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician and completed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

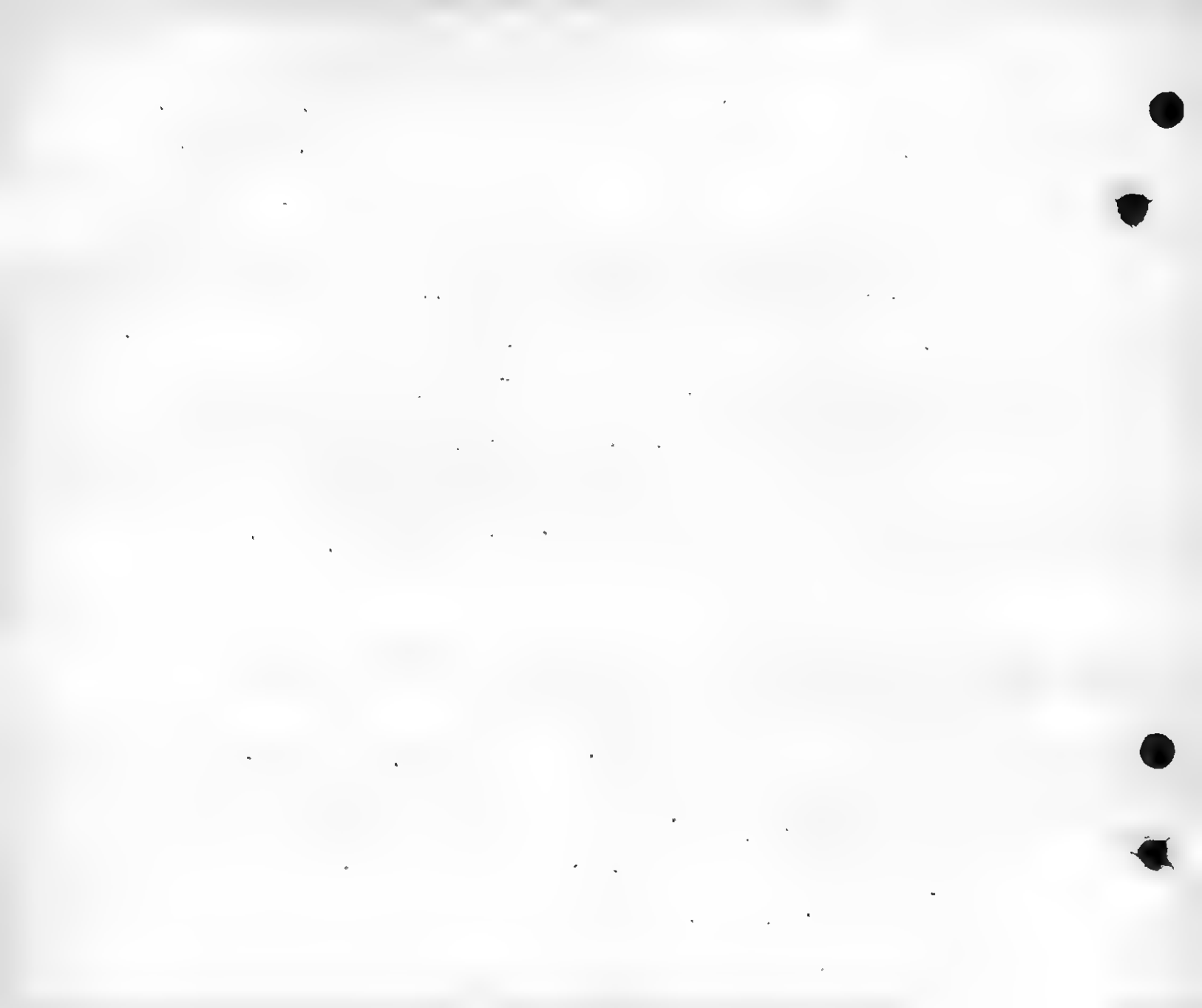
VR A15 (4)
ISM 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04694
CERTIFICATE OF DEATH
04693

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>21 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>North Carolina</u> b. COUNTY <u>Landis</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>No street address</u> d. STREET ADDRESS <u>No street address</u>	
3. NAME OF DECEASED (Type or print) <u>Milton Larry Crowder</u> First Middle Last 4. DATE OF DEATH <u>April 20, 1962</u> Month Day Year 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>January 7, 1940</u> 9. AGE (In years last birthday) <u>22</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS. <u>22</u> yrs.			
10a. USUAL OCCUPATION, G. V. kind of work done during most of working life, even if retired <u>Student</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Lee A. Crowder</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>240-56-7542</u> 17. INFORMANT <u>Amanda Nix</u> Address <u>The Medical Record</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intrapulmonary Hemorrhage</u> <u>204.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Bone Marrow Aplasia</u> DUE TO (c) <u>Chronic myelogenous leukemia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5 months</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>5 weeks</u> <u>5 months</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from <u>March 30, 1962</u> to <u>April 20, 1962</u> that (1) (we) last saw the deceased alive on <u>April 20, 1962</u> and that death occurred at <u>7:15 A.M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Geo. H. Porter III M.D.</u> 22c. PHYSICIAN'S NAME (Type) <u>George H. Porter III, M.D.</u> 22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>4/23/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>WEST LAWN CEMETERY</u> 23d. LOCATION (City, town or county) (State) <u>CHINA GROVE NORTH CAROLINA</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u> ADDRESS <u>1400 CHAPIN ST. N.W. WASH DC</u> 25a. REC'D BY REGISTRAR <u>APR 24 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



VS A15 (4)
15M 9/5B



TO HOSPITAL OR A NURSING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be signed by the hospital or attending physician, or by the funeral director. After this certificate has been signed by the attending physician and completed, it should be filed in the funeral home. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral home. TO HOSPITAL OR A NURSING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be signed by the hospital or attending physician, or by the funeral director. After this certificate has been signed by the attending physician and completed, it should be filed in the funeral home.

VR A15 (4)
15M 7-61

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
04695		04695	
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE -- b. COUNTY --	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Balls Nursing Home		d. STREET ADDRESS 6001 North Dakota Ave., N.W.	
e. LENGTH OF STAY IN b. 3 1/2 yrs.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) AMANDA ELIZABETH DAVIS		4. DATE OF DEATH April 11 1962	
5. SEX female		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/8/1863	
9. AGE (In years last birthday) 98 yrs.		10. IF UNDER 1 YEAR Months 98 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Lewis		14. MOTHER'S MAIDEN NAME Jane Sarah Lewis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT George H. Davis		Address 6001 North Dakota Ave., N.W. Wash. DC.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 442X DUE TO Condi. is, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio vascular Renal Disease DUE TO (c) Arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a); Semiprobable infirmities of age			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of form 18.]			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 4-11-62 to 4-11-62 and that death occurred 7:28 PM from the causes and on the date stated above.			
22a. SIGNATURE James Hawfield		22b. DATE SIGNED 4-11-62	
22c. PHYSICIAN'S NAME (Type) JAMES HAWFIELD		22d. ADDRESS 1150 Conn. Ave NW	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/14/1962	
23c. NAME OF CEMETERY OR CREMATORY Fairfax Cemetery		23d. LOCATION (City, town or county) (State) Fairfax, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		25a. REC'D BY REGISTRAR APR 13 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines		25c. ADDRESS 2901 14th St. N.W. Washington 9, D.C.	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the Director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04696

04696

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN b. <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium + Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>10319 Crestmoor Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>Nellie (NMN) DEAKIN</u>		4. DATE OF DEATH Month <u>4</u> Day <u>6</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-4-06</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
13. FATHER'S NAME <u>HARRY Marmelstein</u>		14. MOTHER'S MAIDEN NAME <u>Frieda ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Sudden</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>History of previous heart disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschaw</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschaw</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL 8, 1962</u>	
22c. NAME OF CEMETERY OR CREMATOR <u>BETH SHOLOM CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>HILLSIDE Md.</u>	
23. FUNERAL DIRECTOR <u>B. Dargansky + Sons</u>		24a. REC'D BY REGISTRAR <u>APR 13 '62</u>	
ADDRESS <u>3501 - 14th St NW</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY in lb <u>4 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>12329 Charles Rd</u>												2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mnty</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>12329 Charles Rd</u>											
3. NAME OF DECEASED (Type or print) <u>Mary Columbia Dement</u>												4. DATE OF DEATH <u>Apr. 17 1962</u>											
5. SEX <u>Female</u>												6. COLOR OR RACE <u>white</u>											
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>												8. DATE OF BIRTH <u>1-23-1890</u>											
9. AGE (in years last birthday) <u>72</u> yrs.												10. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>											
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>												12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
13. FATHER'S NAME <u>Unknown</u>												14. MOTHER'S MAIDEN NAME <u>Anna M. Herold</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>												16. SOCIAL SECURITY NO. <u>Unknown</u>											
17. INFORMANT <u>Jas. Dement</u>												18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 } DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. } DUE TO cause last. (c) _____											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>C.D.G. about 10 yrs ago</u>																							
20a. EXTERNAL CAUSE OF DEATH PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. _____ p.m. _____ Month, Day, Year <u>19</u>												20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)												20f. (City or town) _____ (County) _____ (State) _____											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE <u>Frank J. Bhuschert</u>												CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
EXAMINER'S NAME (Type) <u>FRANK J. Bhuschert</u>												ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>												22b. DATE THEREOF <u>4/20/62</u>											
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>												22d. LOCATION (City, town, or country) <u>SUITLAND, MARYLAND</u>											
23. FUNERAL DIRECTOR <u>John T. Ryan, Inc.</u>												24a. REC'D BY REGISTRAR <u>APR 23 '62</u>											
ADDRESS <u>317 Pa. Ave., SE.</u>												24b. REGISTRAR'S SIGNATURE <u>John T. Ryan</u>											

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04639

04638

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the certificate is "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>2606 Elnora St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Thomas</u> <u>Bailey</u> <u>DeWitt</u>				4. DATE OF DEATH <u>April 17, 1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/7/15</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auditor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>York Air Cond.</u>		11. BIRTHPLACE (State or foreign country) <u>Alabama</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Thos. B. DeWitt, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Anna V. Halsey</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>Navy</u>	
16. SOCIAL SECURITY NO. <u>578-05-5216</u>		17. INFORMANT <u>Brother, William DeWitt, 7209 Arrowood Dr.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarct</u> DOE TO <u>4-20-61</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Insufficiency</u> DOE TO <u>?</u> (c) <u>Coronary arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a).		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Was driver of car which struck tree</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>8:25</u> a.m. <u>PM</u> Month, Day, Year <u>4/16 1962</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) <u>Bethesda</u> (County) <u>Mont.</u> (State) <u>Md.</u>	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4/19/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>	
22d. LOCATION (City, town, or country) <u>Arlington, Virginia</u>				22e. REGISTRAR'S SIGNATURE		22f. REGISTRAR'S SIGNATURE	
23. FUNERAL DIRECTOR <u>Robert A. Humphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>Robert A. Humphrey</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed in by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 42 Days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 500 Gilmore Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Dominick Anthony DI CICCIO SR		4. DATE OF DEATH April 30 19 62		5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 7, 1901		9. AGE (In years last birthday) 60 64 yrs		10. IF UNDER 1 YEAR Months Days 60 64		11. IF UNDER 24 HRS. Hours Min. 60 64			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Officer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown DI CICCIO		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES		16. SOCIAL SECURITY NO. 578 38 0195		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Myocardial infarction arteriosclerotic heart disease		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) March 18, 1962 to April 30, 1962		20g. (County) Montgomery		20h. (State) Md.	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 18, 1962 to April 30, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 30, 1962 , and that death occurred at 9:55 PM from the causes and on the date stated above.		22a. SIGNATURE P. G. LINAWEAVER		22b. DATE SIGNED May 1, 1962		22c. PHYSICIAN'S NAME (Type) P. G. LINAWEAVER LCDR MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		22e. REC'D BY REGISTRAR DATE MAY 3 '62		22f. REGISTRAR'S SIGNATURE Clifford S. Kraus		22g. DATE MAY 3 '62		22h. REGISTRAR'S SIGNATURE Clifford S. Kraus		22i. DATE MAY 3 '62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-4-62		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) Arlington, Virginia		23e. STATE Virginia		23f. CITY OR TOWN Silver Spring, Md.		23g. STREET ADDRESS 8655 Georgia Ave.,		23h. ZIP CODE 20910		23i. PHONE NUMBER 703-281-1111		23j. OTHER INFORMATION W. Chambers Funeral Home	

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled out. The funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04701

CERTIFICATE OF DEATH

Reg. Dist. No. 04700

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Philadelphia</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b <u>3 mos. 1 wk.</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Philadelphia</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1012 Quebec Terrace</u>				d. STREET ADDRESS <u>3818 N. Ninth St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Elizabeth</u> Last <u>Donnelly</u>				4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>19 62</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>Se</u> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 6, 1916</u>		9. AGE (In years last birthday) yrs <u>46</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael McNamee</u>				14. MOTHER'S MAIDEN NAME <u>Devine, Anna</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>165-14-3950</u>		17. INFORMANT <u>Daughter - Ann Warren</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>331X</u> IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>20 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple Sclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 6</u> , 1962, to <u>April 3</u> , 1962, that I last saw the deceased alive on <u>April 3</u> , 1962, and that death occurred at <u>10:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Claire A. Christman</u>				M.D. <u>9703 Riggs Rd.</u>		DATE SIGNED <u>4/3/62</u>	
PHYSICIAN'S NAME (Type) <u>Claire A. Christman, M.D.</u>				Adelphi, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 7, 1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CALVARY Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Consto Hocken</u> <u>Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. T. Atterell</u>				ADDRESS <u>3603 14th St NW</u>		24a. REC'D BY REGISTRAR DATE <u>APR 6 '62</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be filed by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>7328 Piney Branch Road</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>7328-Piney Branch Road</u> d. STREET ADDRESS <u>Takoma Park - Md.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Fred</u> First <u>Fred</u> Middle <u>C.</u> Last <u>Duchring</u> 4. DATE OF DEATH <u>April 1 - 1962</u> Month <u>April</u> Day <u>1</u> Year <u>1962</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>December 26, 1884</u> 9. AGE (in years) <u>77</u> yrs. IF UNDER 1 YEAR F UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Watch Maker</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Carl Duchring</u> 14. MOTHER'S M maiden NAME <u>Anna Fischer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>579-46-0880</u> 17. INFORMANT <u>George C. Duchring</u> Address <u>104 Parkside Rd. S.W.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 422-1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> DUE TO (c) _____ PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>10/1/1</u> to <u>4/1/1</u> , 19 <u>62</u> that (I) <u>(was)</u> last saw the deceased alive on <u>4/1/1</u> , 19 <u>62</u> and that death occurred at <u>5:30 PM</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>A. B. Little</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>A. B. LITTLE MD</u> 22d. ADDRESS <u>6911 5th St. NW Washington DC</u>		22b. DATE SIGNED _____ 25a. REC'D BY REGISTRAR <u>APR 5 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>April 6, 1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Waller</u> ADDRESS <u>234 Carroll St NW D.C.</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04703

04702

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in <u>11da. 19 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>4ccomack</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Greensboro</u> <u>83X3</u> d. STREET ADDRESS <u>General Delivery</u> b. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John</u> <u>Wise</u> <u>Dunton</u> 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>March 26, 1901</u> 9. AGE (In years last birthday) <u>61</u> yrs IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Oswald W. Dunton</u> 14. MOTHER'S MAIDEN NAME <u>Ida E. Taylor</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>076-07-9171</u> 17. INFORMANT <u>Hospital Record</u> Address <u> </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Coronary Thrombosis</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>Three Days</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Alcoholic Liver Disease</u>				20a. ACCIDENT WAS UNDERLYING () OR CONTRIBUTING () CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u> </u>			
20c. TIME OF INJURY Month, Day, Year <u> </u> <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>				21. I certify that (I) (this hospital) attended the deceased from <u>February</u> <u>1962</u> , to <u>April 21</u> <u>1962</u> , that (I) (we) last saw the deceased alive on <u>April 22</u> <u>1962</u> , and that death occurred <u>8:25 PM</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>Stuart L. Nelson</u> 22b. DATE SIGNED <u>4-21-62</u> 22c. PHYSICIAN'S NAME (Type) <u>STUART L. NELSON</u> 22d. ADDRESS <u>7600 Carroll Ave Takoma Park, Maryland</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>4-24-1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>NEELSON CEMETERY</u> 23d. LOCATION (City, town or county) <u>Rural-Pocomoke City, Md.</u> (State) <u> </u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Watson</u> ADDRESS <u>Pocomoke City, Md.</u> 25a. REC'D BY REGISTRAR <u>APR 26 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Christina E. Hanna</u>							

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
04704											
CERTIFICATE OF DEATH											
Reg. Dist. No. 04703											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Montgomery</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>6 years</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>23 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9101 Providence Avenue</u>				d. STREET ADDRESS <u>9101 Providence Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Waters DURING</u>				4. DATE OF DEATH Month Day Year <u>April 2 1962</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 29, 1868</u>		9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Post Office (Retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John T. DURING</u>				14. MOTHER'S MAIDEN NAME <u>Sousse Peeler</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>2-225</u>				17. INFORMANT <u>Mrs. C. J. Norman (Daughter)</u> Address <u>9101 Providence Ave Silver Spring Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure (Sudden)</u>											
DUE TO (b) <u>Arteriosclerotic Heart Disease</u>											
DUE TO (c) <u>Generalized Arteriosclerosis</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of prostate</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1955</u> to <u>April 2, 1962</u> that I last saw the deceased alive on <u>March 31, 1962</u> , and that death occurred at <u>11 A.</u> M, from the causes and on the date stated above.											
ACTUAL SIGNATURE <u>Marion Bankhead</u> M.D.				ADDRESS (Street, city or town, state) <u>9241 Col. Blvd.</u>				DATE SIGNED <u>4/2/62</u>			
PHYSICIAN'S NAME (Type) <u>J. Marion Bankhead</u>				<u>Silver Spring Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-5-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Peace Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Philadelphia Phila, Co, Pennsylvania</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Warner</u> ADDRESS <u>434 Georgia Ave</u>				24a. REC'D BY REGISTRAR <u>APR 5 '62</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			
Warner E. Pumphrey, Inc. Silver Spring, Maryland											

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. If the death occurs at home, it may be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04705

04704

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN TB <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boyd's</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rachel</u> Middle <u>V.</u> Last <u>Edwards</u> b. COLOR OR RACE <u>White</u> c. MARIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> d. DATE OF BIRTH <u>4/22/96</u> e. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR, Months Days IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1962</u>	
5. SEX <u>Male</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>housewife</u> 11. BIRTHPLACE (County & State or foreign country) <u>Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Edgar Van Sickler</u> 14. MOTHER'S MAIDEN NAME <u>Katherine Ball</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> 16. SOCIAL SECURITY NO <u>74</u> 17. INFORMANT <u>Husband, Webster Edwards</u> Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> <u>Atherosclerotic Cardiovascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>422.1</u> (a), stating the underlying cause last. (c) <u>422.1</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Secondarily Infected Rt. Hip, recent fracture</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>November 1954</u> to <u>12 Apr</u> , 1962, that (I) (we) last saw the deceased alive on <u>11 Apr</u> , 1962, and that death occurred at <u>1255</u> M, from the causes and on the date stated above.	
22a. SIGNATURE <u>Gordon M. Smith</u> 22c. PHYSICIAN'S NAME (Type) <u>GORDON M. SMITH</u>		22b. DATE SIGNED <u>12 Apr 1962</u> 22d. ADDRESS <u>Barnesville</u> 22e. MED. DIRECTOR <input checked="" type="checkbox"/> 22f. STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4/14/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u> 23d. LOCATION (City, town or county) <u>Leesburg</u> (State) <u>Virginia</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>William C. Hutton</u> ADDRESS <u>Barnesville, Md.</u> 25a. REC'D BY REGISTRAR <u>APR 17 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04706

04705

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8210 Cedar Street		d. STREET ADDRESS 8210 Cedar Street	
3. NAME OF DECEASED (Type or print) First Robert Middle Crawford Last Ellis		4. DATE OF DEATH Month April Day 19 Year 19 62	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1904
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photo engraver		10b. KIND OF BUSINESS OR INDUSTRY Wash. Post Newspaper	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Ellis		14. MOTHER'S MAIDEN NAME Alice Bergen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 578-09-6562	
17. INFORMANT Mrs. Lois Elliott Ellis		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis, Acute DUE TO Chronic Coronary Arterio-sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. with Angina Pectoris DUE TO Chronic Myocarditis with Cardiac Failure PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arterio-sclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 Undetermined Undetermined	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1, 1949 to Apr. 19, 1962 that (I) (we) last saw the deceased alive on Apr. 19, 1962 and that death occurred at 6:30 P.M. from the causes and on the date stated above			
22a. SIGNATURE George L. Ball		22b. DATE SIGNED Apr 19, 1962	
22c. PHYSICIAN'S NAME (Type) George L. Ball		22d. ADDRESS 1630 Georgia Rd Silver Spring, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-23-62	
23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore Baltimore Co., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond Warner E. Pumphrey, Inc.		25a. REC'D BY REGISTRAR DATE APR 23 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

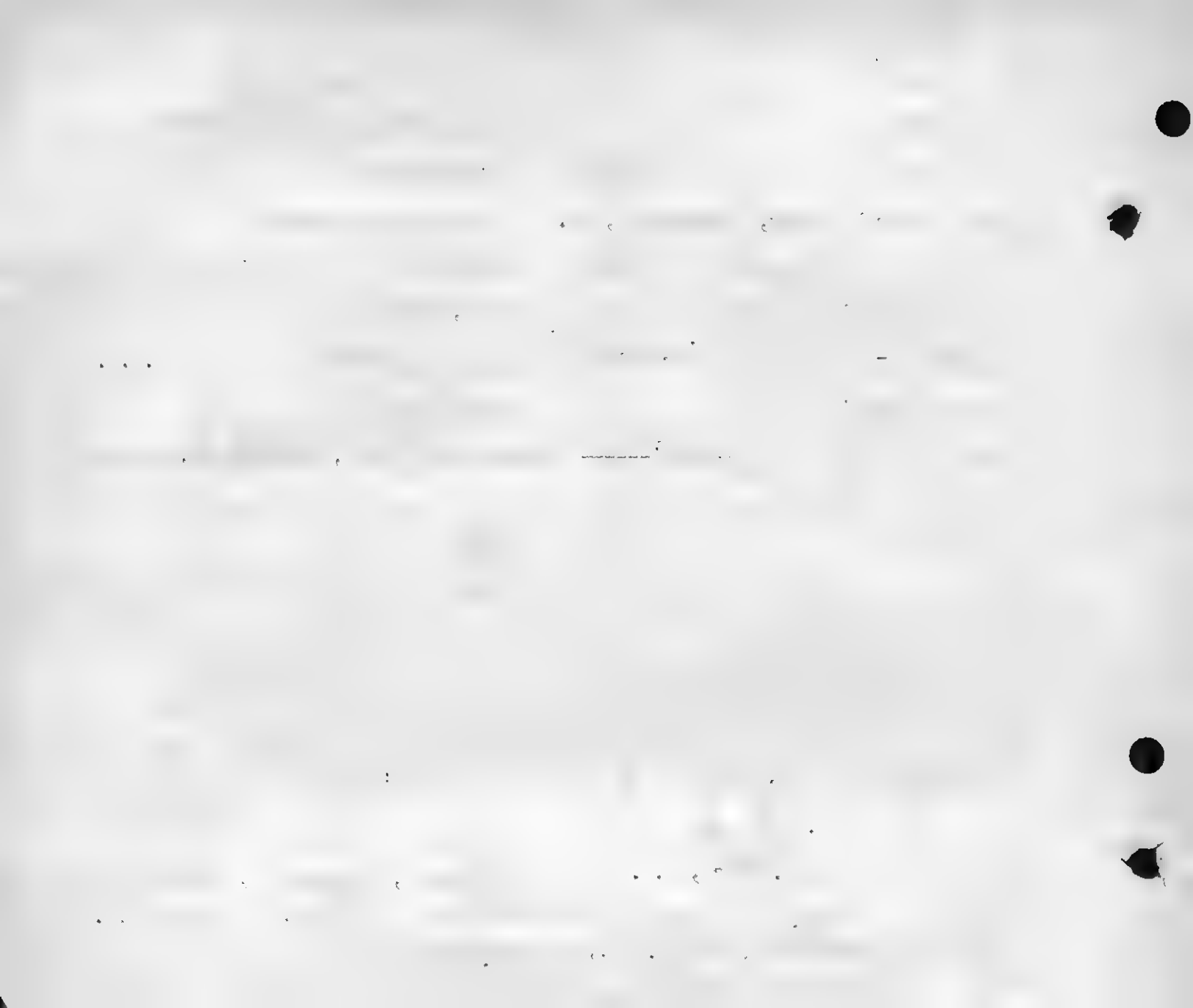
M

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be filled in by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 5 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park d. STREET ADDRESS 7329 Carroll Avenue	
3. NAME OF DECEASED (Type or print) Charles (None) Fenwick		4. DATE OF DEATH April 7, 1962	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 31, 1894	
9. AGE (in years last birthday) 67		10. IF UNDER 1 YEAR Months Days Hours Min. 1 day	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer - retired		12. BIRTHPLACE, Country & State or foreign country, Scotland U.S.A.	
13. FATHER'S NAME Charles Fenwick		14. MOTHER'S MAIDEN NAME Agnes Stevens	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 213-38-2507	
17. INFORMATION The Medical Record		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmia DUE TO Diffuse Bronchopneumonia DISEASE TO Multiple Myeloma CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that X (this hospital) attended the deceased from April 2, 1962 to April 7, 1962 , that X (we) last saw the deceased alive on April 7, 1962 , and that death occurred at 12:53 AM from the causes and on the date stated above.			
22a. SIGNATURE John C. Marsh		22b. DATE SIGNED 4/7/62	
22c. PHYSICIAN'S NAME (Type) John C. Marsh, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1962	
23c. NAME OF CEMETERY OR CREMATORY Tue April 10 Congressional Cemetery		23d. LOCATION (City, town or county) (State) S.E. Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pimphrey		25a. REC'D BY REGISTRAR DATE APR 11 '62	
25b. REGISTRAR'S SIGNATURE Warner E. Pimphrey, INC. 8434 Ga. Ave., Silver Spring Md.		25c. REGISTRAR'S SIGNATURE Warner E. Pimphrey	



TO HOSPITAL OR MEDICAL CERTIFICATION: The law requires that the death certificate be executed within 24 hours after death. It may be executed by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
04708 Item 9 Film G311 4/10/62 jwk 04707											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural) c. LENGTH OF STAY IN TB 20 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 4714 Chelsea Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				3. NAME OF DECEASED (Type or print) First Theresa Middle Sylinda Last GARDNER 4. DATE OF DEATH Month APRIL Day 8 Year 19 62 5. SEX Female 6. COLOR OR RACE Caucasian 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 5-24-83 19. AGE (In years last birthday) 78 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 11. BIRTHPLACE (County & State, or foreign country) Washington, D.C. 12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Harry Boyer				14. MOTHER'S MAIDEN NAME Sylinda BRIGHT				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ----- 16. SOCIAL SECURITY NO. ----- 17. INFORMANT Hospital Records Address -----			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 420.1 DUE TO Acute myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Fracture Rt hip PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 Days INTERVAL BETWEEN ONSET AND DEATH 10 hrs											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) Patent was 19 days post op insertion of hip prosthesis, and convalescing well; developed acute M.I. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, of item 18.) 20c. TIME OF INJURY Month, Day, Year April 18 62 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital Bethesda Montg. Md. 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 19 19 62 to April 8 19 62 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 8 19 62 , and that death occurred at 3:12 PM the causes and on the date stated above. 22a. SIGNATURE Leo V. Willett M.D. 22b. DATE SIGNED April 8, 1962 22c. PHYSICIAN'S NAME (Type) LEO V. WILLETT LCDR MCUSN 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md. 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 4-11-62 23c. NAME OF CEMETERY OR CREMATORY Arlington National 23d. LOCATION (City, town or county) (State) Arlington, Virginia 24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pamphrey ADDRESS Bethesda, Md. 25a. REC'D BY REGISTRAR APR 12 '62 25b. REGISTRAR'S SIGNATURE Arthur L. Hester											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital, or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 7,61

1

04709

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 2 Film Item 3

infor. 10/1/62 Item 3

Birth cer. 1wk

1. PLACE OF DEATH
a. COUNTY **Montgomery**
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Bethesda (Rural)**
c. LENGTH OF STAY IN 1b **1 day**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **U.S. Naval Hospital**

2. USUAL RESIDENCE (Where deceased lived, if institutions Read note before admission)
a. STATE **MARYLAND**
b. COUNTY **Montgomery**
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Forest View**
d. STREET ADDRESS **109 Iroquois Way**
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
First Middle Last
Shari Baby Lynne GASCHE

4. DATE OF DEATH Month Day Year
APRIL 28 1962

5. SEX **Female** 6. COLOR OR RACE **Caucasian** 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH **27 APRIL 1962** 9. AGE (in years last birthday) **1** yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **WIDOWED **DIVORCED **27 APRIL 1962******

11. BIRTHPLACE (County & State, or foreign country) **Montgomery Maryland** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **James Russell GASCHE** 14. MOTHER'S MAIDEN NAME **Elaine C. GASCHE**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **NO** 16. SOCIAL SECURITY NO. **Hospital Records** 17. INFORMANT Address **11 hours**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **7545** **CONGENITAL HEART DISEASE** DUE TO
Conditions, if any, which gave rise to immediate cause (b) **7545** DUE TO
(a), stating the underlying cause last. (c) **7545**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a. 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. **19** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from **27 APRIL 1962**, to **28 APRIL 1962** that ☒ (we) last saw the deceased alive on **28 APRIL 1962**, and that death occurred **17A** M, from the causes and on the date stated above.

22a. SIGNATURE **M. C. O'Bannon** M.D. 22b. DATE **28 APRIL 1962** 22c. PHYSICIAN'S NAME (Type) **M.C. O'BANNON, LT MC USN** 22d. ADDRESS **U.S. Naval Hospital, Bethesda, Md.**

23a. BURIAL, CREMATION, REMOVAL, (Specify) **Burial** 23b. DATE THEREOF **5-1-62** 23c. NAME OF CEMETERY OR CREMATORY **ARLINGTON NATIONAL CEMETERY** 23d. LOCATION (City, town or county) (State) **ARLINGTON, VIRGINIA**

24. FUNERAL DIRECTOR'S SIGNATURE **Robert A. Pumphrey** ADDRESS **7551 Wisc. Ave., Bethesda, Md.** 25a. REC'D BY REGISTRAR **MAY 1 '62** 25b. REGISTRAR'S SIGNATURE **Arthur L. Huns**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with 24 hours after death. It may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04710

04709

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 2 weeks d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bel Pre Nursing Home 2601 Bel Pre Rd.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Kentucky b. COUNTY Nelson c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Bardstown d. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) Edward Alexander Gaylor		4. DATE OF DEATH April 9 1962	
5. SEX male		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 28, 1876	
9. AGE (In years, If UNDER 1 YEAR, If UNDER 24 HRS. last birthday) 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Internal Revenue Agent U.S. Gov't	
11. BIRTHPLACE County & State, or foreign country Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Gaylor		14. MOTHER'S MAIDEN NAME Sally Dabney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 400-48-6160	
17. INFORMANT Kermit L. Gaylor		Address 8601 Manchester Rd, S.S., Md.	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cerebral insufficiency (senility) DUE TO Cerebral arteriosclerosis DUE TO Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Unknown INTERVAL BETWEEN ONSET AND DEATH Known 2 yrs. Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
21. I certify that (I) (the hospital) attended the deceased from Dec 2, 1959 to April 8, 1962 , that (I) (we) last saw the deceased alive on April 8, 1962 , and that death occurred at 4 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Aaron H. Traum		22b. DATE SIGNED April 9, 1962	
22c. PHYSICIAN'S NAME (Type) Aaron H. Traum, M.D.		22d. ADDRESS 8237 Georgia Avenue, Silver Spring, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 4-13-62	
23c. NAME OF CEMETERY OR CREMATORY Bardstown Cemetery		23d. LOCATION (City, town or county) (State) Bardstown Nelson Co, Kentucky	
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.		25a. REC'D BY REGISTRAR APR 11 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Use 4 may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

04711
M
1
MONTGOMERY
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04710
04710
CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma PARK, MD</u>		c. LENGTH OF STAY in lb <u>3/14/62 to 4/4/62</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON SANITARIUM + HOSPITAL</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>422 Mansfield Rd. 21</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GERTRUDE LEE GESSFORD</u>		d. STREET ADDRESS <u>SILVER SPRING MD</u>	
5. SEX <u>FE</u>		4. DATE OF DEATH Month Day Year <u>4 4 1962</u>	
6. COLOR OR RACE <u>WH</u>		8. DATE OF BIRTH 10/17/89 90 72 yrs.	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		19. AGE (In years last birthday) IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (Country & State, or foreign country) <u>Washington, D.C.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amc U.S.A.</u>	
13. FATHER'S NAME <u>George W. Redman</u>		14. MOTHER'S M maiden name <u>TREVINIA SEGER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Stuart Gessford</u>		Address <u>207 E. Melbourne Ave, Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>147.1</u> DUE TO <u>Malequancy, underinflated, Cap +</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>leap lungs = pleural effusion</u> DUE TO (c) <u>+ congestive failure</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myocardial infarction</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>1959</u> to <u>4 April 1962</u> , that (1) (we) last saw the deceased alive on <u>4 April 1962</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Ernest E. Harmon</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>4-4-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ernest E. Harmon</u>		22d. ADDRESS <u>9301 Colesville Rd, Silver Spring, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-7-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Zisch</u> <u>Warner E. Pumphrey, Inc. Silver Spring, Maryland</u>		25a. REC'D BY REGISTRAR <u>APR 6 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>			

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04711

Items 4 & 5b, Film 0312 5/30/62

1. PLACE OF DEATH
a. COUNTY **Montgomery** MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Bethesda (Rural)**
c. LENGTH OF STAY IN 1b **7 days**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **U. S. Naval Hospital**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE **Virginia**
b. COUNTY
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Staunton**
d. STREET ADDRESS **1011 Baylor Street**
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
First **Henry** Middle **Doyle** Last **GIBSON**

4. DATE OF DEATH **April 27 1962**

5. SEX **Male** 6. COLOR OR RACE **Caucasian** 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH **July 4, 1932** 9. AGE (In years last birthday) **29** yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **U. S. Marine Corps** 10b. KIND OF BUSINESS OR INDUSTRY **Virginia** 11. BIRTHPLACE (County & State, or foreign country) **USA** 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME **Luther Gibson** 14. MOTHER'S MAIDEN NAME **Jannie Robertson**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **Yes** 16. SOCIAL SECURITY NO. **6-50 - 11-53** 17. INFORMANT **Hospital Records** Address **Same as #1**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Hodgkins Disease**
201X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH **8 years**

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year **19** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from **April 20, 1962** to **April 27, 1962**, that ☒ (we) last saw the deceased alive on **April 27, 1962**, and that death occurred at **10:10AM** from the causes and on the date stated above.

22a. SIGNATURE **Vernon W. Houk, LCDR MC USN** 22b. DATE SIGNED **4-27-62**
22c. PHYSICIAN'S NAME (Type) **V. N. HOUK, LCDR MC USN** 22d. ADDRESS **U. S. Naval Hospital, Bethesda, Md.**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE THEREOF **May 1, 1962** 23c. NAME OF CEMETERY OR CREMATORY **Augusta Memorial Park** 23d. LOCATION (City, town or county) (State) **Fishersville, Virginia**

25a. REC'D BY REGISTRAR **May 3 '62** 25b. REGISTRAR'S SIGNATURE **Arthur S. Kline**

25c. REGISTRAR'S SIGNATURE **Arnold F. Brummer**

25d. ADDRESS **Hamrick & Co. Inc., 18 W. Frederick St., Staunton**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 74 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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04712
MONTGOMERY
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>Rt 2 Stewart Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Donald Emerson Golladay</u>		4. DATE OF DEATH Month <u>4</u> Day <u>22</u> Year <u>1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-20-17</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Navy</u>	
13. FATHER'S NAME <u>James Emerson</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Newman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>578-03-1631</u>	
17. INFORMANT <u>Mrs. Evelyn Golladay - wife</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> 20.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of fever, heart disease</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20c. TIME OF INJURY Month <u>4</u> Day <u>19</u> Year <u>1962</u> Hour <u>a.m.</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-26-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u>		22d. LOCATION (City, town, or country) (State) <u>Falls Church Fairfax Co., Virginia</u>	
23. FUNERAL DIRECTOR <u>Raymond A. Ziska</u>		24a. REC'D BY REGISTRAR <u>APR 27 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Carl E. Hunt</u>		24c. REGISTRAR'S NAME <u>Carl E. Hunt</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completed. Pages 3 and 4 may be completed by the funeral director. After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04714

04713

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>4407 Ridge St.</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>A.</u> Last <u>Goodwin</u>		4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>1962</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/15/57</u>
9. AGE (in years last birthday) <u>44</u> yrs		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>14</u>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired (Plasterer)</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C., U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John T. Goodwin</u>	
14. MOTHER'S MAIDEN NAME <u>Nellie Sullivan</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>yes</u> 16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Myra L. Goodwin</u> Address <u>13900 15th Ave N.W., Bethesda, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> Conditions, if any, which gave rise to immediate cause (b) <u>CACHEXIA; BRONCHIECTASIS; EMPHYSEMA</u> (c) <u>CARCINOMA OF ESOPHAGUS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN</u> <u>4 DAYS</u> <u>1 YEAR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? <u>YES</u> <input type="checkbox"/> <u>NO</u> <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 17, 1961</u> to <u>APRIL 30, 1962</u> that (I) (we) last saw the deceased alive on <u>APRIL 29, 1962</u> and that death occurred at <u>10:15 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph D. Connor</u>		22b. DATE SIGNED <u>May 6, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH D. CONNOR, M.D.</u>		22d. ADDRESS <u>9420 Old Georgetown Rd., Bethesda, Md.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/4/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25. REC'D BY REGISTRAR <u>May 4 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		25c. ADDRESS <u>Bethesda, Maryland</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician.

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MONTGOMERY
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN IL 4 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SUBURBAN HOSP.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 2107 Hilderose Street	
3. NAME OF DECEASED (Type or print) ESTELLE F. GOTT		4. DATE OF DEATH 4-22-1962	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-9-90	
9. AGE (In years last birthday) 72		10. IF UNDER 1 YEAR: Months 4 Days 22 Hours 19 Min. 62	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife Own Home		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FROMMEYER, FRANCIS		14. MOTHER'S MAIDEN NAME KIME, SARAH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-420003	
17. INFORMANT John S. Gott (Son)		Address 2107 Hilderose St. S.S. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4113X DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Arrhythmia Fibrillation Hypertensive Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) 20 yrs		INTERVAL BETWEEN ONSET AND DEATH 4 days	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) No		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) No	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1950 to 22 April 1962 , that (I) last saw the deceased alive on 21 April 1962 , and that death occurred at 5:05 PM , from the causes and on the date stated above.			
22a. SIGNATURE Merton L. White		22b. DATE SIGNED 22 April 62	
22c. PHYSICIAN'S NAME (Type) Merton L. White		22d. ADDRESS 11134 Georgia Ave Silver Spring Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) 4-25-62		23b. DATE THEREOF 4-25-62	
23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		23d. LOCATION (City, town or county) (State) Forest Glen, Montgomery Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Zisk		25a. REC'D BY REGISTRAR APR 26 1962	
25b. REGISTRAR'S SIGNATURE Warner E. Pumphrey, Inc. Silver Spring, Maryland		25c. REGISTRAR'S SIGNATURE Warner E. Pumphrey	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04715

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> M b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN b. <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>New Alexandria</u> d. STREET ADDRESS <u>703 16th</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Warren</u> <u>Laise</u> <u>Granger</u> First Middle Last				4. DATE OF DEATH <u>April 19, 1962</u> Month Day Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>June 29, 1898</u>		9. AGE (In years last birthday) <u>63</u> yrs IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Marine Corps Officer</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Howard Granger</u>			14. MOTHER'S MAIDEN NAME <u>Lillian Laise</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Hospital Records</u> Address _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>myocardial ischemia</u> DUE TO (c) <u>arteriosclerotic coronary insufficiency</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). <u>Diabetes mellitus</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY: Month, Day, Year _____ Hour a.m. _____ p.m. _____ 20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>April 18, 1962</u> to <u>April 19, 1962</u> that (we) last saw the deceased alive on <u>April 19, 1962</u> , and that death occurred at <u>10:35 AM</u> the causes and on the date stated above. 22a. SIGNATURE <u>Joseph H. Eusterman</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>JOSEPH H. EUSTERMAN LT MC USNR</u> 22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>							
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-24-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>			
23d. LOCATION (City, town or county) <u>Arlington, Virginia</u>		24. BURIAL DIRECTOR'S SIGNATURE <u>Everly Wheatley</u> <u>Everly Wheatley Funeral Home, Braddock Rd.,</u>					
25a. REC'D BY REGISTRAR DATE <u>APR 23 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Robert S. Thomas</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04717
04716

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 3 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cur-Lu Nursing Home		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park d. STREET ADDRESS 805 Kennebec Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLARA Isabelle GREEN First Middle Last 4. DATE OF DEATH APRIL 11 1962 Month Day Year		5. SEX FEMALE 6. COLOR OR RACE CAUC. 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH February 25, 1884 9. AGE (In years IF UNDER 1 YEAR, IF UNDER 24 HRS. last birthday) Months Days Hours Min. 76 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Own home 11. BIRTHPLACE County & State, or foreign country, New York 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Issac Gary 14. MOTHER'S MAIDEN NAME Caroline Coseo	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO 577 16 3559A 17. INFORMANT Dorothy G. Lockwood Address Rt 5 - Frederick, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE + 2 - 0 DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) AND HYPERTENSIVE CARDIOVASCULAR DISEASE INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS 10 YRS 12 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) NONE 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. City or town (County) (State)	
21. I certify that (this hospital) attended the deceased from MAY 1968 to PRESENT , that (I) (we) last saw the deceased alive on DOA 11 APRIL 1962 and that death occurred at 1250M (1325 AM) from the cause and on the date stated above.			
22a. SIGNATURE Robert P. Hughes, Jr. 22c. PHYSICIAN'S NAME (Type) Robert P. Hughes, Jr.		22b. DATE SIGNED 11 APRIL 62 22d. ADDRESS WALTER REED GENERAL HOSPITAL	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 4-13-62 23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery 23d. LOCATION (City, town or county) (State) Arlington, Virginia		24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey 25a. REC'D BY REGISTRAR APR 16 '62 25b. REGISTRAR'S SIGNATURE C. E. S. Hays	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

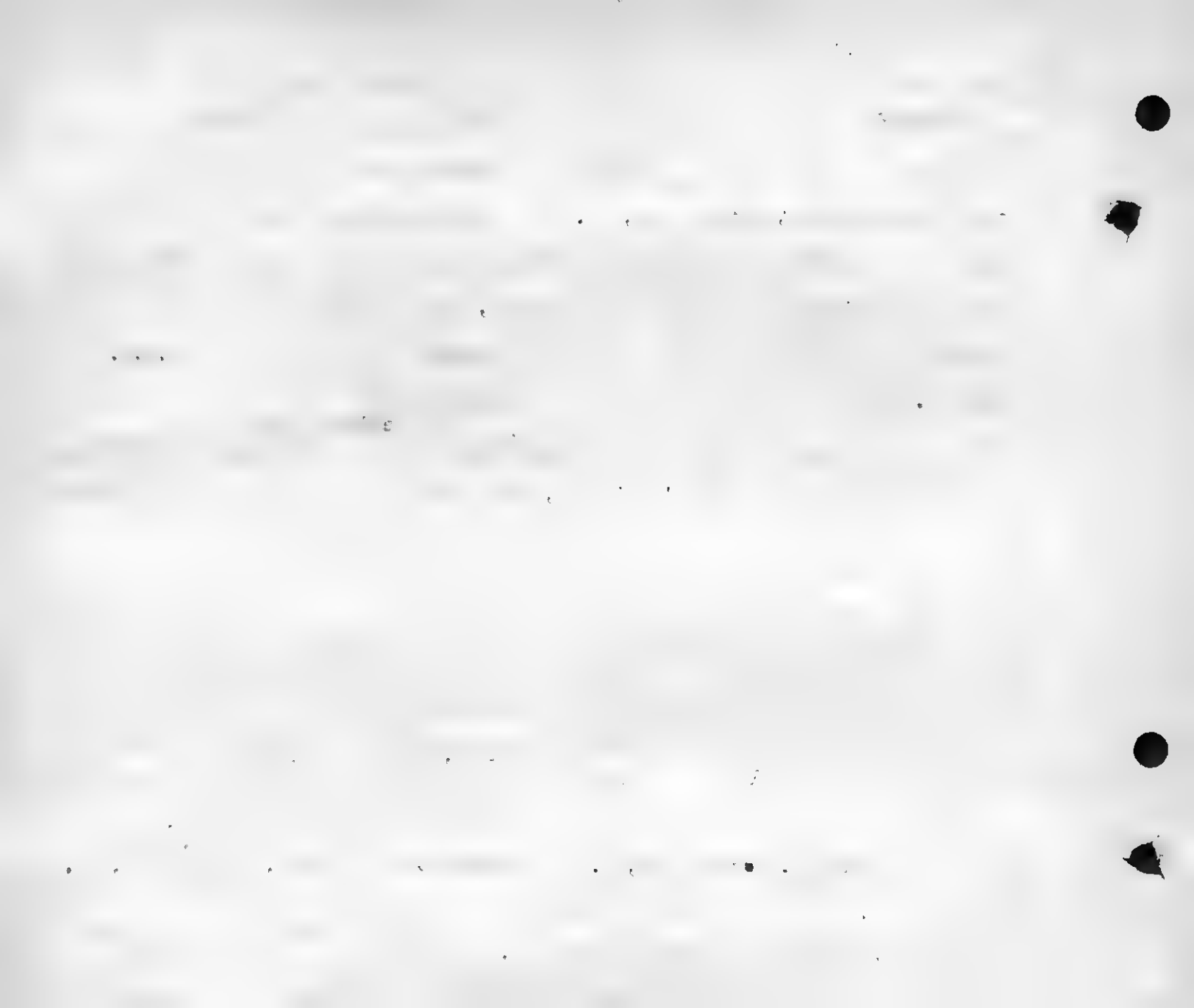
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04718

CERTIFICATE OF DEATH

04717

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN TB 13 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gaithersburg d. STREET ADDRESS 6 East Diamond Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Addie Marie Griffith First Middle Last 4. DATE OF DEATH April 30 1962 Month Day Year		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH May 8, 1893 9. AGE (In years last birthday) 68 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James E. King 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No 16. SOCIAL SECURITY NO. None 17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkin's Disease, generalized 201X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 16 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18, _____) 20c. TIME OF INJURY Hour a.m. _____ p.m. _____ Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 17, 1962 to April 30, 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 30, 1962 , and that death occurred at 4:05 P.M. from the causes and on the date stated above. 22a. SIGNATURE Geo. H. Porter, III 22c. PHYSICIAN'S NAME (Type) George H. Porter, III, M.D.		22b. DATE SIGNED MAY 1, 1962 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 5-2-62 23c. NAME OF CEMETERY OR CREMATORY Forest Oak 23d. LOCATION (City, town or county) (State) Gaithersburg, Md.		25a. REC'D BY REGISTRAR DATE MAY 3 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Kline	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04719

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN TB

3 yrs

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

6311 Tulsa Lane

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

MD

b. COUNTY

Montgomery

45 Bethesda

d. STREET ADDRESS

6311 Tulsa Lane

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

Salvatore Joseph Guidi

4. DATE OF DEATH

Apr 8 1962

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

☒ NEVER MARRIED ☐

8. DATE OF BIRTH

1-1-1889

9. AGE (In years last birthday)

73 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Produce Clerk

10b. KIND OF BUSINESS OR INDUSTRY

retired

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF WHAT COUNTRY?

Italy

13. FATHER'S NAME

Baldassare Guidi

14. MOTHER'S MAIDEN NAME

Sabina Pagni

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

223-07-7300

17. INFORMANT

Joseph Guidi (Son)

Address

Itum 2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Acute Myocardial Insufficiency

INTERVAL BETWEEN ONSET AND DEATH

Acute

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

Coronary Thrombosis

(b)

DUE TO

Coronary Arteriosclerosis

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Was passenger in car involved in accident

20c. TIME OF INJURY Month, Day, Year

4-7-1962

20d. INJURY OCCURRED

White ☐ Not White ☒ at work ☐ at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

street

20f. (City or town)

Bethesda

(County)

Montgomery

(State)

MD

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Frank J. Brosch

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DATE SIGNED

DEPUTY MEDICAL EXAMINER ☒

Apr 8 1962

EXAMINER'S NAME (Type)

FRANK J. Brosch

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

4/10/62

22c. NAME OF CEMETERY OR CREMATORY

Gate of Heaven Cem.

22d. LOCATION (City, town, or country)

Silver Spring, Maryland

23. FUNERAL DIRECTOR

Robert A. Pumphrey, Bethesda, Maryland

24a. REC'D BY REG STRAR

DATE APR 13 '62

24b. REGISTRAR'S SIGNATURE

Arthur S. Thomas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the reason in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

04721

04720

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) KENSINGTON c. LENGTH OF STAY in b 4 mos. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) KENSINGTON GARDENS SANITARIUM				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE D.C. b. COUNTY WASHINGTON DC c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 4 d. STREET ADDRESS 1101 Massachusetts Ave., NW e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ROBERT		First CRIGLER Middle GUNLEY Last		4. DATE OF DEATH Month APRIL Day 20 Year 1962			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 13, 1881		9. AGE (in years last birthday) 80 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RAINGER - US Govt		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia			
13. FATHER'S NAME John W. GULLEY		14. MOTHER'S MAIDEN NAME BETTIE HASSELTINE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT JAMES C. ROGERS 4102 Aspen St. CC, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Cecum DUE TO Conditions, if any, which gave rise to immediate cause (b) 153.0 (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). INTERVAL BETWEEN ONSET AND DEATH 10 mos.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (the hospital) attended the deceased from 12-26 , 19 61 to 4-20 , 19 62 that (I) was last saw the deceased alive on 4-20 , 19 62 , and that death occurred at 11:15 P.M. from the causes and on the date stated above.							
22a. SIGNATURE James W. Egan		22b. ADDRESS 7720 Wisconsin Ave. - Bethesda, Md.		22c. PHYSICIAN'S NAME (Type) James W. Egan			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/24/62		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery Prince George Co. Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE APR 26 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04722

Item 23b 411m 1311 1/2/62 mh

04721

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 39 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY A c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 840 Monroe Street	
3. NAME OF DECEASED (Type or print) First Louis Middle Joseph Last Gulliver		4. DATE OF DEATH Month April Day 17 Year 19 62	
5. SEX Male 6. COLOR OR RACE Caucasian 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month November Day 6 Year 1883	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Naval Officer 10b. KIND OF BUSINESS OR INDUSTRY Maine		9. AGE (In years IF UNDER 1 YEAR last birthday) 78 yrs 11. BIRTHPLACE (County & State, or foreign country) USA	
13. FATHER'S NAME John Gulliver		14. MOTHER'S MAIDEN NAME Adellaide Derby	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 16. SOCIAL SECURITY NO. World War I		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Carcinoma of bladder c DUE TO metastasis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Syno phis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 10, 1962 to April 17, 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 17, 1962 and that death occurred at 5:30 PM from the causes and on the date stated above.			
22a. SIGNATURE R. E. AKERS M.D. 22c. PHYSICIAN'S NAME (Type) R. E. AKERS LT MC USN		22b. DATE April 18, 1962 ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF April 23, 1962		23c. NAME OF CEMETERY OR CREMATORY Arlington National 23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey 24b. ADDRESS Bethesda, Md. 24c. PHONE NO. Robert A. Pumphrey Funeral Home, 7557 Wisc. Ave.		25a. REC'D BY REGISTRAR APR 23 '62 25b. REGISTRAR'S SIGNATURE C. E. S. Hume	

Corrected copy Film G311 4/26/62 mh

1800

1800

4-24-62

VR A15 (4)
15M 9/59

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the Director of Health, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Director of Health. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P143—Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 04724 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04723

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 CHEVY CHASE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		d. STREET ADDRESS <u>3608 THORNAPPLE ST.</u>	
3. NAME OF DECEASED (Type or print) <u>NORMAN Brierley</u>		DATE OF DEATH <u>APRIL 26 1962</u>	
5. SEX <u>Male</u>		8. DATE OF BIRTH <u>9/1/86</u>	
6. COLOR OR RACE <u>White</u>		9. AGE (In years last birthday) <u>76</u> yrs.	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. AGE (In years last birthday) <u>76</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rear Admiral, U.S. Coast Guard</u>		11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Hall</u>		14. MOTHER'S MAIDEN NAME <u>Emma Brierley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		17. INFORMANT <u>Wladys Hall (wife)</u> Address <u>Item 2</u>	
16. SOCIAL SECURITY NO. <u>---</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Thrombosis, Lt. middle cerebral artery</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
(b) <u>Cerebral arteriosclerosis</u>		months <u>---</u>	
(c) <u>---</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<u>Hypertensive heart disease - yes</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brochart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Brochart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22b. DATE THEREOF <u>4/30/62</u>		DATE SIGNED <u>4-26-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>		Address (Street, city, town, or county) <u>Brooklyn, New York</u>	
22d. LOCATION (City, town, or country) (State)		24a. REC'D BY REGISTRAR <u>APR 30 '62</u>	
23. FUNERAL DIRECTOR <u>The S.H. Hines Co.</u>		24b. REGISTRAR'S SIGNATURE <u>Walter E. ...</u>	
Address <u>2901 14th St. N.W. Washington 9, D.C.</u>			

CERTIFICATE OF DEATH

04725

Item 23b Film 0311 1/1/62

04724

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda (rural)

c. LENGTH OF STAY IN

5 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

U.S. Naval Hospital

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

Thomas

Henry

HALL

5. SEX

Male

Cauc

WIDOWED

DIVORCED

8. DATE OF BIRTH

5-17-89

4. DATE OF DEATH

Month

Day

Year

April

11

1962

9. AGE (In years last birthday) IF UNDER 1 YEAR, IF UNDER 24 HRS.

72 yrs.

Months Days

Hours M n.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Washington D.C.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Thomas M. Hall

14. MOTHER'S MAIDEN NAME

Louise Kessel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Wife: Mrs Rose A. Hall, Same as #2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Acute Pulmonary edema

260X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

Arteriosclerotic Cardiovascular Disease unk.

Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH

30 minutes

unk.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour e.m. p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (this hospital) attended the deceased from April 6, 1962, to April 11, 1962, that (we) last saw the deceased alive on April 11, 1962, and that death occurred at 6:10, from the causes and on the date stated above

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

D.I. STEIN, LT MC USN

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS

22b. DATE SIGNED

11 April 1962

22d. ADDRESS

U.S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

April 16, 1962

23c. NAME OF CEMETERY OR CREMATORY

Arlington National

23d. LOCATION (City, town or county)

Arlington

Virginia

24. FUNERAL DIRECTOR'S SIGNATURE

T. COSTELLO FUNERAL HOME, 1722 N. Capitol St. WDC

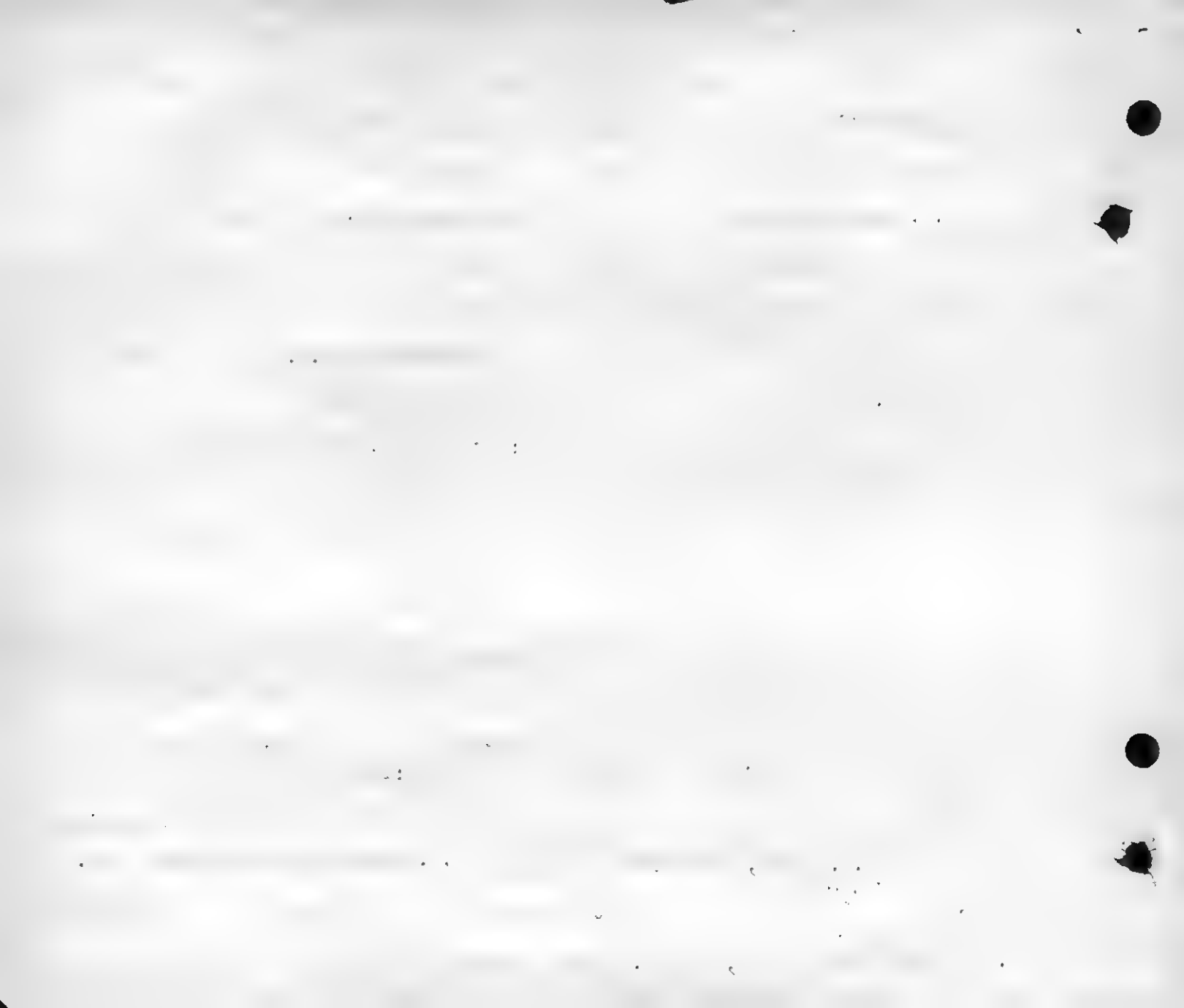
25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE APR 16 '62

Arthur L. Kessel

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate may be completed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04725

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN 1b <u>11 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kensington Gardens Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8716 Colesville Road</u>			
3. NAME OF DECEASED (Type or print) <u>Edward Norman Hamilton</u>		4. DATE OF DEATH <u>April 3 1962</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Feb. 6, 1880</u>		9. AGE (In years, est. birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>			
11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>			
11. BIRTHPLACE (County & State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Hamilton</u>			
14. MOTHER'S MAIDEN NAME <u>Euphemia Work</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-10-9963</u>			
17. INFORMANT <u>Silver</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>Cor pulmonale</u> <u>Emphysema (Pulmonary)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a) <u> </u>		19. INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>3 years</u> <u>10 years</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u>		20g. (County) <u> </u>		20h. (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>August 1953</u> to <u>present</u> , that (I) (we) last saw the deceased alive on <u>April 3 1962</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>William Lewis</u>		22b. DATE SIGNED <u>4 April 62</u>		22c. PHYSICIAN'S NAME (Type) <u>William Lewis MD</u>			
22d. ADDRESS <u>1726 M St. NW Wash DC</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-6-62</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) <u>Prince George's Co, Maryland</u>		23e. REC'D BY REGISTRAR <u>APR 6 '62</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>		25a. ADDRESS <u>8434 Georgia Ave Silver Spring, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed in by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the cause, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04727 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 047226

1. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN 1b 20A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland
b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1st Silver Spring
d. STREET ADDRESS 103 Parkway Rd.

3. NAME OF DECEASED (Type or print)
First Robert Middle Ellsworth Last Harding

4. DATE OF DEATH
Month April Day 27 Year 1962

5. SEX M
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH October 12, 1915
9. AGE (In years last birthday) 46 yrs. If UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Station
10b. KIND OF BUSINESS OR INDUSTRY Service Station
11. BIRTHPLACE (State or foreign country) Gaithersburg
12. CITIZEN OF WHAT COUNTRY? American

13. FATHER'S NAME Robert Donald Harding
14. MOTHER'S MAIDEN NAME Ivy Bell Gray

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give year or dates of service) WW 2
16. SOCIAL SECURITY NO. 1-10-100000
17. INFORMANT Wife Address 103 Parkway Rd.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
(a) IMMEDIATE CAUSE SUBARACHNOID HEMORRHAGE
(b) DUE TO SKULL FRACTURE
(c) DUE TO FALL DOWN A FLIGHT OF STAIRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a. Fall down stairs at home

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
INTERVAL BETWEEN ONSET AND DEATH minutes

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall down stairs at home

20c. TIME OF INJURY Month, Day, Year 2:40 p.m. 4-27 1962
20d. INJURY OCCURRED While ☐ at work Not While ☒ at work Home
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) (County) (State) Silver Spring monty md

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASS STANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE Frank J. Boshart M.D.
EXAMINER'S NAME (Type) FRANK J. BOSCHART
DATE SIGNED 4-27-62

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF May 1-1962
22c. NAME OF CEMETERY OR CREMATORY Arlington National
22d. LOCATION (City, town, or county) (State) Arlington Virginia

23. FUNERAL DIRECTOR Arthur Statters ADDRESS 254 Carroll St
24a. REC'D BY REGISTRAR APR 30 1962
24b. REGISTRAR'S SIGNATURE Arthur Statters

MEDICAL CERTIFICATION

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
5M 9 60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 047227

047228

1. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park
c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium Hosp - R 2

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE Maryland
b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
d. STREET ADDRESS Marlowe Rd

3. NAME OF DECEASED (Type or print) Chester ST George Haynes

4. DATE OF DEATH 4 26 1962

5. SEX M

6. COLOR OR RACE W

7. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 9-9-07-54

9. AGE (In years last birthday) 4 yrs. IF UNDER 1 YEAR: Months 4 Days 26 IF UNDER 24 HRS.: Hours 19 Min. 2

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer

10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Louis Haynes

14. MOTHER'S MAIDEN NAME Margaret Stanger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 42-46 US Army

16. SOCIAL SECURITY NO. 42-46 US Army

17. INFORMANT Mrs Mrs Elfrieda Haynes

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
DUE TO
Conditions, if any, which gave rise to immediate cause (b)
(a), stating the underlying cause last (c) Stroke
DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 4 26 1962

20d. INJURY OCCURRED White ☐ Not White ☐ at work ☐ at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 4-26-62

ACTUAL SIGNATURE Frank J. Brosch

EXAMINER'S NAME (Type) FRANK J. BROSCH

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 4-30-62

22c. NAME OF CEMETERY OR CREMATORY Washington National

22d. LOCATION (City, town, or country) (State) Washington - Virginia

23. FUNERAL DIRECTOR Arthur Walters ADDRESS 204 Birch St. NE Takoma Park - DC

24a. REC'D BY REGISTRAR DATE APR 30 '62

24b. REGISTRAR'S SIGNATURE Arthur S. Kane

1
FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the Medical Examiner's Office in writing. The word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Examiner's Office. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 9 60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04729 04728

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN b. <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. & Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>17100 Maple Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Leland Merrill Hedgcock</u>		4. DATE OF DEATH Month <u>4</u> Day <u>2</u> Year <u>1962</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>Wh</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 15 - 01</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		9b. AGE (In years last birthday) <u>60</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Govt.</u>	
11. BIRTHPLACE (State or foreign country) <u>Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George G. Hedgcock</u>		14. MOTHER'S MAIDEN NAME <u>Della Merrill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Esther A. Hedgcock</u> Address <u> </u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u> </u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u> </u>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22a. ACTUAL SIGNATURE <u>Frank J. Broschart</u> EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		22b. DATE OF SIGNATURE <u>4-2-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or country) <u>Washington DC</u>	
22e. FUNERAL DIRECTOR <u>J. Arthur Walters, 254 Carroll St. NW Wash DC</u>		22f. REC'D BY REGISTRAR <u>APR 5 1962</u>	
22g. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>		22h. DATE <u>APR 5 1962</u>	

1
FOR STATE
HEALTH DEPT.

TO DEF. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the certificate is "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04729

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN <u>TAKOMA PARK</u> c. LENGTH OF STAY IN b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Langley Park</u> d. STREET ADDRESS <u>1806 MERRIMACK DRIVE</u>	
3. NAME OF DECEASED (Type or print) <u>MR. Guy Glen Hendershot</u>		4. DATE OF DEATH <u>4 3 1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-14-16</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cable Splicer C&P Tel Co</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania</u>	
10. FATHER'S NAME <u>William Hendershot</u>		11. BIRTHPLACE (State or foreign country) <u>AMER.</u>	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		13. SOCIAL SECURITY NO. <u>?</u>	
14. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage & laceration</u> 776x DUE TO <u>bullet wound in skull (rt)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u></u>		15. PATIENT'S CHIEF COMPLAINT <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u></u>			
16a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u>Self-inflicted bullet wound in rt skull</u>		16b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Home</u>	
17a. TIME OF INJURY <u>5:15 p.m.</u> Month, Day, Year <u>4-2 1962</u>		17b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
18. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		19. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
20. ACTUAL SIGNATURE <u>Frank J. Bruschant</u>		21. DATE SIGNED <u>4-3-62</u>	
22. EXAMINER'S NAME (Type) <u>FRANK J. BRUSCHANT</u>		23. ADDRESS (Street, city, town, or county) <u>4-3-62</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE THEREOF <u>4/6/62</u>	
25. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery Prince George's County, Md.</u>		26. LOCATION (City, town, or country) <u>Prince George's County, Md.</u>	
27. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>		28. DATE <u>APR 6 1962</u>	

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TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. If the death occurs in a hospital or at home, the certificate may be signed by the attending physician and completed by the funeral director. If the death occurs elsewhere, the certificate must be signed by the attending physician and completed by the funeral director. The law requires that the death certificate be executed within 24 hours after death. If the death occurs in a hospital or at home, the certificate may be signed by the attending physician and completed by the funeral director. If the death occurs elsewhere, the certificate must be signed by the attending physician and completed by the funeral director.

TO FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. If the death occurs in a hospital or at home, the certificate may be signed by the attending physician and completed by the funeral director. If the death occurs elsewhere, the certificate must be signed by the attending physician and completed by the funeral director. The law requires that the death certificate be executed within 24 hours after death. If the death occurs in a hospital or at home, the certificate may be signed by the attending physician and completed by the funeral director. If the death occurs elsewhere, the certificate must be signed by the attending physician and completed by the funeral director.

VR A15 (4)
15M 9/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04731
04730

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 45 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE New York b. COUNTY Onondaga c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Syracuse d. STREET ADDRESS 404 Westmoreland Avenue	
3. NAME OF DECEASED (Type or print) Nellie First (None) Middle Herzog Last		4. DATE OF DEATH April 6, 1962 Month April Day 6 Year 1962	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 7, 1905	
9. AGE (In years last birthday) 56 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Lithuania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Hillel Rutstein	
14. MOTHER'S MAIDEN NAME Sarah Gesner		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv. ca.) No	
16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mitral Stenosis DUE TO (b) Rheumatic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) February 20, 1962 to April 6, 1962	
21. I certify that (I) (this hospital) attended the deceased from February 20, 1962 to April 6, 1962 , that (I) (we) last saw the deceased alive on April 6, 1962 , and that death occurred at 6:50 PM from the causes and on the date stated above.		22a. SIGNATURE Dean T. Mason	
22b. DATE SIGNED 4/7/62		22c. PHYSICIAN'S NAME (Type) Dean Mason, M.D.	
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland		22e. LOCATION (City, town or county) (State) Syracuse, New York	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 4-8-62		23b. DATE THEREOF 4-8-62	
23c. NAME OF CEMETERY OR CREMATORY Anashe Sfard Cemetery		23d. LOCATION (City, town or county) (State) Syracuse, New York	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR APR 13 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. ADDRESS Bethesda, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased was in the hospital or attended by the hospital or attending physician, the certificate should be filled out by the hospital or attending physician. If the deceased was not in the hospital or attended by the hospital or attending physician, the certificate should be filled out by the funeral director. After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04732

04731

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in it <u>27 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>35 4103 Ferrara Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Gerard August Frans Heystee</u> First Middle Last 4. DATE OF DEATH <u>4-16-1962</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>4-10-21</u> Month Day Year 9. AGE (in years last birthday) <u>40</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Canceller Netherlands Embassy</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Foreign Service</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Netherlands</u> 12. CITIZEN OF WHAT COUNTRY? <u>Netherlands</u>		13. FATHER'S NAME <u>Gerard A.F. Heystee</u> 14. MOTHER'S MAIDEN NAME <u>Eugenie Volleman</u> Mother's first name = <u>Josephine</u> Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> NONE 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>U.S. H. records.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>abscess of lesser sack</u> <u>541.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>duodenal ulcer</u> (c) <u>polycythemia vera</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>3/2/62</u> , 19 <u>62</u> , to <u>4/16</u> , 19 <u>62</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>4/15</u> , 19 <u>62</u> , and that death occurred at <u>5 A.M.</u> , from the causes and on the date stated above.	
22a. SIGNATURE <u>Phillip Bloemsma</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Phillip Bloemsma</u>		22b. DATE SIGNED <u>4-16-62</u> 22d. ADDRESS <u>5911 16th St., N.W., Washington, D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4-18-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u> 23d. LOCATION (City, town or county) <u>Silver Spring, Montgomery Co., Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond P. Ziska</u> <u>Warner E. Pumphrey, Inc., Silver Spring, Maryland</u> 25a. REC'D BY REGISTRAR <u>APR 18 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be filled out by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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04733

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04732

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gaithersburg c. LENGTH OF STAY IN TB 1 yr d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rest Haven. Resthome			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 10102 Pierce Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Nattie Middle Agnes Last Hipsley			4. DATE OF DEATH Month Apr Day 10th Year 1962		
5. SEX Female			6. COLOR OR RACE White		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH Oct 5th 1876		
9. AGE (In years last birthday) 85 yrs.			10. IF UNDER 1 YEAR Months 8 Days 13		
11. IF UNDER 24 HRS. Hours 1 Min. 5			12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME Rufus Phoebeus			14. MOTHER'S MAIDEN NAME Mary P. English		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			16. SOCIAL SECURITY NO. Arthur R. Hipsley. Silver Spring. Md.		
17. INFORMANT Arthur R. Hipsley. Silver Spring. Md.			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Heart Failure DUE TO (b) Arteriosclerotic Heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Senility PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1961 to 4/10 , 19 62 , that (I) (we) last saw the deceased alive on 4/9 , 19 62 , and that death occurred at 6:25 A.M. from the causes and on the date stated above.					
22a. SIGNATURE Luciano I. Leal			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) Luciano I. Leal			22d. ADDRESS Gaithersburg Md		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 14-14-62		
23c. NAME OF CEMETERY OR CREMATORY Forest Oak			23d. LOCATION (City, town or county) (State) Gaithersburg. Md.		
24. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. Gaithersburg. Md.			25a. REC'D BY REGISTRAR APR 16 '62		
25b. REGISTRAR'S SIGNATURE Ernest C. Gartner					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be signed by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04734 CERTIFICATE OF DEATH 04733

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN Is 119 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1610 Varnum Place, N.E. d. STREET ADDRESS 47X	
3. NAME OF DECEASED (Type or print) Howard Lee Holmes		4. DATE OF DEATH Month April Day 11 Year 19 62	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 22, 1922
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Manager		10b. KIND OF BUSINESS OR INDUSTRY Sales	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME (First name unknown) Bell		14. MOTHER'S MAIDEN NAME Hattie Coleman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 17. INFORMANT 577-28-2164 The Medical Record	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Hydrocephalus DUE TO Brain Tumor Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO 15 months		INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis, Right lower lobe pneumonia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 13, 1961 to April 11, 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 11, 1962 , and that death occurred at 4:35 AM from the causes and on the date stated above.			
22a. SIGNATURE Thomas R. Cate		22b. DATE SIGNED 4/11/62	
22c. PHYSICIAN'S NAME (Type) Thomas R. Cate, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 4-16-1962		23b. DATE THEREOF Arlington National	
23c. NAME OF CEMETERY OR CREMATORY St. Myer		23d. LOCATION (City, town or county) va	
24. FUNERAL DIRECTOR'S SIGNATURE Knapp's Funeral Home, 384 R.I. Ave. N.W.		25a. REC'D BY REGISTRAR APR 16 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. House			

TO HOSPITAL OR A PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be executed by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7,61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
04735 Item 8 Film G311 4/12/62											
04734											
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. LENGTH OF STAY IN b. <i>MARYLAND</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>MD</i>		b. COUNTY <i>DC</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Kensington Gardens Sanitarium</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS <i>4802 BERRYWOOD DR.</i>		4. DATE OF DEATH Month <i>APRIL</i> Day <i>4</i> Year <i>1962</i>		5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	
3. NAME OF DECEASED (Type or print) <i>KATHARINE B</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1878</i>		9. AGE (In years last birthday) <i>84</i>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>	
11. FATHER'S NAME <i>Henry S. Clapp</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. MOTHER'S MAIDEN NAME <i>Sarah Brightman</i>		14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>NO</i>		15. SOCIAL SECURITY NO. <i>NO</i>		16. INFORMANT <i>MARY H. CLAPP, 4802 BERRYWOOD DR.</i>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bilateral Bronchopneumonia</i> (b) <i>Cerebral Thrombosis</i> (c) <i>DUE TO</i>		18. INTERVAL BETWEEN ONSET AND DEATH <i>1 Week</i> <i>6 months</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20d. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20e. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20f. (City or town) <i>4-4</i>		20g. (County) <i>DC</i>		20h. (State) <i>DC</i>		21. I certify that (I) (this hospital) attended the deceased from <i>2/28/49</i> to <i>4-4</i> , 19 <i>62</i> , that (I) (we) last saw the deceased alive on <i>4-3</i> , 19 <i>62</i> , and that death occurred at <i>4:00 PM</i> , from the causes and on the date stated above.	
22a. SIGNATURE <i>Horace H. Custis, Jr.</i>		22b. DATE SIGNED <i>4-4-62</i>		22c. PHYSICIAN'S NAME (Type) <i>Horace H. Custis, Jr.</i>		22d. ADDRESS <i>1852 Columbia Road, N. W., Wash. 9, D.C.</i>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ATTENDING PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>		23b. DATE THEREOF <i>APR 4 1962</i>		23c. NAME OF CEMETERY OR CREMATORY <i>1405 COLUMBIAN AVE</i>		23d. LOCATION (City, town or county) <i>300 N ST NW Wash DC</i>		23e. (State) <i>DC</i>		24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Hannon</i>	
25a. REC'D BY REGISTRAR DATE <i>APR 6 '62</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hannon</i>		25c. ADDRESS <i>Wash DC</i>		25d. (City, town or county) <i>DC</i>		25e. (State) <i>DC</i>		25f. (Country) <i>USA</i>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, removal, and in any event within 72 hours after death.

04735

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04735

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> Minutes			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10209 Douglas Ave</u>			d. STREET ADDRESS <u>13006 Matey Rd</u>		
3. NAME OF DECEASED (Type or print) <u>John Anthony Howland</u>			4. DATE OF DEATH Month <u>4</u> Day <u>30</u> Year <u>1962</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-26-43</u>		9. AGE (In years last birthday) <u>19</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash D.C</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>	
13. FATHER'S NAME <u>John O Howland</u>			14. MOTHER'S MAIDEN NAME <u>Marie LeBuffle</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>No</u>			16. SOCIAL SECURITY NO. <u>377-56-6401</u>		17. INFORMANT <u>John O Howland - Same</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PENDING</u> Cardiac arrhythmia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ventricular fibrillation</u> DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II. of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> a.m. <u>19</u> p.m.	Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect on <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschert</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>May 1 1962</u>		
22b. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		
22d. DATE THEREOF <u>5-4-62</u>			22e. LOCATION (City, town, or country) (State) <u>Bears Den, Montgomery Co., Md.</u>		
23. FUNERAL DIRECTOR <u>Raymond Aziska</u> ADDRESS <u>8034 Georgia Ave.</u>			24a. REC'D BY REGISTRAR <u>MAY 3 '62</u>		
24b. REGISTRAR'S SIGNATURE <u>Wm. E. P. ...</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04737

04736

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN b. 4 1/2 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 9912 Kensington Parkway		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington d. STREET ADDRESS 9912 Kensington Parkway	
3. NAME OF DECEASED (Type or print) First Ira Middle S. Last Hull 4. DATE OF DEATH Month April Day 8 Year 1962		5. SEX female 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH Feb. 13, 1876 9. AGE (years) 86 yrs. IF UNDER 1 YEAR Months Days Hours M.in. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Own home 11. BIRTHPLACE (County & State, or foreign country) Elgin, Illinois 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ira L. Sherman 14. MOTHER'S MAIDEN NAME Fanny Burney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No 16. SOCIAL SECURITY NO. None 17. INFORMANT Marjorie Hull Address Kensington, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Static DUE TO (b) Stasis and debility DUE TO (c) Cerebral arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis	
19. INTERVAL BETWEEN ONSET AND DEATH 1 week 6 months years		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 1, 1961 to April 8, 1962 that (I) (we) last saw the deceased alive on April 7, 1962 and that death occurred at 3:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE John T. Hagenbucher		22b. DATE SIGNED 4-8-62	
22c. PHYSICIAN'S NAME (Type) John T. HAGENBUCHER		22d. ADDRESS 915 19th St., N.W.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-11-62	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey		25a. REC'D BY REGISTRAR APR 11 '62	
25b. REGISTRAR'S SIGNATURE Warner E. Pumphrey, Inc.		25c. REGISTRAR'S SIGNATURE Warner E. Pumphrey, Inc.	

1
FOR STATE
HEALTH DEPT.

TO DELIVER BY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please secure the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04738 04732

1. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park
c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland
b. COUNTY Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington
d. STREET ADDRESS 2707 Calgary Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Amanda
4. DATE OF DEATH 4 1 1962

5. SEX F
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 11-8-88-89
9. AGE (In years last birthday) 73 yrs. UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired nurse
10b. KIND OF BUSINESS OR INDUSTRY Nursing
11. BIRTHPLACE (State or foreign country) N.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Baker
14. MOTHER'S MAIDEN NAME Amanda (unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. None
17. INFORMANT Hospital Records

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Acute coronary insufficiency
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe generalized arteriosclerosis
(c) Fractured left hip
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 102-2

19. INTERVAL BETWEEN ONSET AND DEATH 9 days

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Slipped on curb - fracturing left hip
20c. TIME OF INJURY Month, Day, Year 11-8-62 Hour 3:15 p.m. 20d. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.) Wheaton Plaza
20e. (City or town) Wheaton (County) Montgomery (State) MD

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 4-3-62
22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery
22d. LOCATION (City, town, or country) (State) Rockville Montgomery Co, Maryland

23. FUNERAL DIRECTOR Raymond A. Ziska ADDRESS 3434 Georgia Ave.
24a. REC'D BY REGISTRAR Warner E. Pumphrey, Inc. DATE APR 3 '62
24b. REGISTRAR'S SIGNATURE C. Shur E. Hanna

ACTUAL SIGNATURE Frank J. Broschert
EXAMINER'S NAME (Type) FRANK J. BROSCHELT
DATE SIGNED 4-1-62

TO HOSPITAL OR AFTER DEATH: The law requires that the death certificate be executed within 24 hours after death. If the death occurs in a hospital or nursing home, the certificate may be completed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04739 CERTIFICATE OF DEATH 04738

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>21 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Resmor Sanatorium + Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3801 Conn Ave, Washington DC</u> d. STREET ADDRESS <u>47x3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph Richard Hutsell</u> First Middle Last		4. DATE OF DEATH <u>4-28-1962</u> Month Day Year	
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/18/83</u> 9. AGE (In years last birthday) <u>78</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Interior Decorator</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Tenn</u>
13. FATHER'S NAME <u>William Wythe Hutsell</u>		14. MOTHER'S MAIDEN NAME <u>Martha A. Reagan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>333-03-8293</u>	
17. INFORMANT <u>Mrs. Anna May Hutsell</u>		Address <u>Wash, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolus</u> DUE TO <u>Arricular fibrillation</u> Conditions, if any, which gave rise to immediate cause (a), stating if a underlying cause last. <u>Arteriosclerotic Cardiovascular disease</u> DUE TO <u>10 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>Prostatic hypertrophy</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>3 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-8-1962</u> to <u>4-28-1962</u> that (I) (we) last saw the deceased alive on <u>4-26-1962</u> and that death occurred at <u>5</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u> M.D.		22b. DATE SIGNED <u>4-28-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. Roger Kottz M.D.</u>		22d. ADDRESS <u>3701 Connecticut Ave. NW Wash DC</u>	
23a. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> DATE THEREOF <u>April 30, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>	
23b. LOCATION (City, town or county) (State) <u>Pr. Geo. Co., Maryland</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W.</u>		25a. REC'D BY REGISTRAR <u>APR 30 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, and in any event, within 72 hours after death, the law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
04740			
04739			
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY <u>Rockville</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>1200 North Washington Street</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>30</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Karen Patrice Isreal</u>		4. DATE OF DEATH <u>April 4, 1962</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5 August 1955</u>	
9. AGE (In years last birthday) <u>6</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clarence Isreal</u>		14. MOTHER'S MAIDEN NAME <u>Florence Dobbs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>The Medical Record, The Clinical Center, Bethesda, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive gastrointestinal hemorrhage</u> 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Acute lymphocytic leukemia</u> DUE TO (c) <u>22 Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 5, 1962</u> to <u>April 4, 1962</u> , that (I) (we) last saw the deceased alive on <u>April 4, 1962</u> , and that death occurred at <u>5:05 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Thorne S. Winter, III</u> M.D.		22b. DATE SIGNED <u>April 5, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thorne S. Winter, III</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/8/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park.</u>		23d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		25a. REC'D BY REGISTRAR <u>APR 11 1962</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		25c. ADDRESS <u>Rockville, Md.</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04741

04740

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kooleville (Rural)</u> c. LENGTH OF STAY IN 1b _____ d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kooleville</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EXIE</u> Middle <u>KING</u> Last <u>JAMISON</u>				4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1962</u>			
5. SEX <u>Female</u>				6. COLOR OR RACE <u>White</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>Aug. 10 1879</u>			
9. AGE (In years last birthday) <u>82</u> yrs.				IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY _____			
11. BIRTHPLACE (County & State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>James S. Purdum</u>				14. MOTHER'S MAIDEN NAME <u>Alice Rebecca Burdette</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. _____			
17. INFORMANT <u>Purdum E. Jamison</u>				Address <u>Kooleville, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right hemiplegia</u> <u>334 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>ARTERIOSCLEROSIS.</u> DUE TO (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>osteoporosis osteoarthritis</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) _____							
20c. TIME OF INJURY Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 1953</u> to <u>April 4, 1962</u> that (I) (we) last saw the deceased alive on <u>April 3, 1962</u> , and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE <u>John G. Fawcett</u> M.D.				22b. DATE SIGNED _____			
22c. PHYSICIAN'S NAME (Type) <u>John G. Fawcett</u>				22d. ADDRESS <u>Boyd's Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/7/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bethesda Methodist</u>		23d. LOCATION (City, town or county) <u>Browningsville Md.</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William C. Hilton</u>				25a. REC'D BY REGISTRAR <u>William C. Hilton</u>			
25b. REGISTRAR'S SIGNATURE _____				DATE <u>APR 9 '62</u>			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician. It should be signed by the attending physician and completed in by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04742

04741

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS 3913 Morrison St. N.W.	
3. NAME OF DECEASED (Type or print) Lewis Wise JENNINGS JR.		4. DATE OF DEATH Month Day Year April 23, 1962	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 6, 1881
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours M.n. 80	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Officer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lewis Wise Jennings Sr.		14. MOTHER'S MAIDEN NAME Nancy Lewis Goodloe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1905 - 1945		16. SOCIAL SECURITY NO. unk	
17. INFORMANT Mrs. Lucy P. Jennings		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia atrial fibrillation malnutrition			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 22, 1962 , to April 23, 1962 , that M (we) last saw the deceased alive on April 23, 1962 , and that death occurred 6:10AM from the causes and on the date stated above			
22a. SIGNATURE J. H. Eusterman		22b. DATE April 23, 62	
22c. PHYSICIAN'S NAME (Type) J. H. EUSTERMAN, LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 26 April 1962	
23c. NAME OF CEMETERY OR CREMATORY Arlington, National		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey		25a. REC'D BY REGISTRAR APR 25 '62	
Home, 7557 Wisc. Ave.,		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04743

04742

Item 22 Film 6311

1/12/62 mb

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Elkridge

c. LENGTH OF STAY IN

20 A.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Montgomery General Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

md

b. COUNTY

Montg

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

13 Sandy Spring (rural)

d. STREET ADDRESS

Dr Bird Rd.

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED
(Type or print)

Amos

First

Middle

Last

Johnson

4. DATE OF DEATH

Apr

Day

2

Year

1962

5. SEX

male

6. COLOR OR RACE

col

7. MARRIED

☐ NEVER MARRIED

8. DATE OF BIRTH

2-19-1904

9. AGE (In years last birthday)

58 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

laborer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

md

12. CITIZEN OF WHAT COUNTRY?

U.S.C.

13. FATHER'S NAME

Amos I. Johnson

14. MOTHER'S MAIDEN NAME

Carie Bellows

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Harp Ricard

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

90000 DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

SUB ARACHNOID HEMORRHAGE

(b) FRACTURE BASE OF SKULL (LEFT)

(c) FELL FROM A STAIRS

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Fell down stair steps at home

20c. TIME OF INJURY

Hour a.m. 3:30

Month, Day, Year

4-2 1962

20d. INJURY OCCURRED

While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Home

20f. (City or town)

Sandy Spring

(County)

Montg

(State)

md

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion

death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED

4-2-62

ACTUAL SIGNATURE

Frank J. Broschat

M.D.

EXAMINER'S NAME (Type)

FRANK J. BROCHAT

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

April 4, 1962

22c. NAME OF CEMETERY OR CREMATORY

Ash Memorial

22d. LOCATION (City, town, or country)

Sandy Spring

(State)

Md.

23. FUNERAL DIRECTOR

ADDRESS

Robert L. Snowden, Rockville, Md.

24a. REC'D BY REGISTRAR

DATE APR 6 '62

24b. REGISTRAR'S SIGNATURE

William S. Thomas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04744

04743

1. PLACE OF DEATH
a. COUNTY **Montgomery** MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Bethesda (Rural)**
c. LENGTH OF STAY IN 1b **10 days**
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **U. S. Naval Hospital**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE **Maryland** b. COUNTY **Prince George**
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Clinton**
d. STREET ADDRESS **7911 Old Alexandria Road**
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Last
Bessie Mae JOHNSON
4. DATE OF DEATH Month Day Year
April 14 1962

5. SEX **Female** 6. COLOR OR RACE **Caucasion** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH
December 24, 1919 9. AGE (In years last birthday) **42** yrs. F UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housewife** 10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country) **, Tenn.** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Clarence Jenkins** 14. MOTHER'S MAIDEN NAME **Bessie Kate Graham**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) **no** 16. SOCIAL SECURITY NO. **266-10-4109** 17. INFORMANT **Hospital Records** Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Aortic Insufficiency**
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, (b) **421.1** DUE TO
DUE TO (c)
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e), 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. **19** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from **April 4, 1962, to April 14, 1962**, that ☒ (we) last saw the deceased alive on **April 14, 1962**, and that death occurred at **11:45 pm** from the causes and on the date stated above.
22a. SIGNATURE **J. J. Ryskamp Jr.** 22b. DATE SIGNED **April 15, 1962**
22c. PHYSICIAN'S NAME (Type) **J. J. RYSKAMP JR.** 22d. ADDRESS **U. S. Naval Hospital, Bethesda, Maryland**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE THEREOF **April 16, 1962** 23c. NAME OF CEMETERY OR CREMATORY **Riverside Memorial Cemetery Jacksonville, Florida** 23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE **Robert A. Humphrey** ADDRESS **Bethesda, Md.** 25a. REC'D BY REGISTRAR **APR 17 '62** 25b. REGISTRAR'S SIGNATURE **Arthur L. Hume**

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1967

1967

...

1967



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Payment may be obtained by the hospital or attending physician. Payment may be obtained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04745

04744

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germanatown</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pleasant View Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germanatown</u> d. STREET ADDRESS <u>Pleasant View Nursing Home</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Marshall Edward Johnson</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>Colored</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u> 13. FATHER'S NAME <u>Alexander Johnson</u> 14. MOTHER'S MAIDEN NAME <u>Rosetta</u>		4. DATE OF DEATH <u>April 23 1962</u> 8. DATE OF BIRTH <u>Sept. 8, 1890</u> 9. AGE (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give year or dates of service) <u> </u> 16. SOCIAL SECURITY NO. <u> </u> 17. INFORMANT <u>W Mildred Stewart - Germanatown - Md</u> Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Degeneration</u> 592X DUE TO (b) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DJE TO (c) <u>Nephritis, Chr. Interstitial</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (e) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4-6 mos</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year <u> </u> Hour <u> </u> e.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that (I) <u>this hospital</u> attended the deceased from <u>2 April 1962</u> to <u>23 April 1962</u> that (I) <u>two</u> last saw the deceased alive on <u>23 Apr 1962</u> and that death occurred at <u>4:05 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>D. A. Butler</u>		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u>D. A. Butler</u>		22d. ADDRESS <u>2710 North Howard Rd</u>	
23a. BURIAL, CREMATION <u>Burial</u> (Specify)		23b. DATE THEREOF <u>4/26/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Asbury.</u>		23d. LOCATION (City, town or county) <u>Germanatown, Md.</u> (State) <u> </u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Surode</u> ADDRESS <u>Rockville, Md.</u>		25a. REC'D BY REGISTRAR <u> </u> DATE <u>MAY 1 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04746

04745

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>1 day + 11 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanatorium and Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>10901 Lombardy Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Lise</u> Middle <u>Flora</u> Last <u>Kasmir</u>		4. DATE OF DEATH Month <u>April</u> Day <u>34</u> Year <u>1962</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>April 23, 1946</u>		9. AGE (In years last birthday) <u>16</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> M. n. <u> </u>		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>New York State</u>			
13. FATHER'S NAME <u>Charles Kasmir</u>		14. MOTHER'S MAIDEN NAME <u>Babette Ross.</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO.</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Hospital Record.</u> Address <u> </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage (Subarachnoid)</u> Conditions, if any, which gave rise to immediate cause (b) <u>Probable ruptured aneurysm</u> (a), stating the underlying cause last, (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) <u>None.</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u> </u>							
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u>		(County) <u> </u>		(State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>April 22, 1962</u> to <u>April 24, 1962</u> that (I) (we) last saw the deceased alive on <u>April 23, 1962</u> and that death occurred at <u>1 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Ralph Stiller</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Ralph Stiller</u>							
22b. DATE SIGNED <u>April 24, 1962</u> 22d. ADDRESS <u>1110 Spring Street, Sil. Spr.</u>							
23a. BURIAL, CREMATION, RITUAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/26/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARL. NATL. Cem.</u>			
23d. LOCATION (City, town or county) <u>ARL. VA.</u>		(State) <u> </u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Deedee Funeral Home</u>			
25a. REC'D BY REGISTRAR DATE <u>APR 27 '62</u>		25b. REGISTRAR'S SIGNATURE <u>William L. Thorne</u>					

MEDICAL CERTIFICATION

2

1

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
 04746

04747

04746

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillendale</u> d. STREET ADDRESS <u>1403 Oakview Drive</u>		3. NAME OF DECEASED (Type or print) First <u>SIMON</u> Middle <u>-</u> Last <u>KATZ</u> 4. DATE OF DEATH <u>April 6, 1962</u> Day <u>6</u> Year <u>1962</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>September 8, 1918</u> 9. AGE (In years last birthday) <u>43</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supply Manager</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. of the Army</u> 11. BIRTHPLACE (County & State, or foreign country) <u>New York</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>LOUIS KATZ</u> 14. MOTHER'S MAIDEN NAME <u>BERTHA FISHMAN (Deceased)</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> 16. SOCIAL SECURITY NO. <u>104-01-5012</u> 17. INFORMANT <u>S. Barbara Katz</u> 18. ADDRESS <u>1403 Oakview Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.) <u> </u>		20c. TIME OF INJURY Month, Day, Year <u> </u> 19 <u> </u> Hour a.m. <u> </u> p.m. <u> </u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <u> </u> at work <u> </u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (1) <u>Boris Rabkin</u> attended the deceased from <u>Nov. 1961</u> to <u>Apr 6, 1962</u> that (1) <u>Yes</u> last saw the deceased alive on <u>April 5, 1962</u> , and that death occurred at <u>12:51 A.M.</u> from the causes and on the date stated above					
22a. SIGNATURE <u>Boris Rabkin</u>		22b. DATE SIGNED <u>4/6/62</u>		22c. PHYSICIAN'S NAME (Type) <u>BORIS RABKIN, M.D.</u>	
22d. ADDRESS <u>1019 University Blvd., East, Sil Spg, Md</u>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS <u> </u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Apr 8, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Geo. Washington Cemetery</u>	
23d. LOCATION (City, town or county) <u>Hyattsville, Md.</u>		23e. (State) <u> </u>		23f. REC'D BY REGISTRAR <u> </u>	
23g. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		23h. DATE <u>APR 9 '62</u>		23i. REGISTRAR'S SIGNATURE <u> </u>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04747

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 43 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 6918 Decatur Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Timothy John Kearney		4. DATE OF DEATH April 18 1962	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 10, 1904	
9. AGE (In years last birthday) 57		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool Setter	
11. BIRTHPLACE (Country, State, or foreign country) Idaho		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Timothy John Kearney, Sr.		14. MOTHER'S MAIDEN NAME Arvilla Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes 1925 - 1932		16. SOCIAL SECURITY NO. 044-01-0638	
17. INFORMANT The Medical Record		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypotension DUE TO (b) Metastatic adenocarcinoma of the kidney DUE TO (c) Azotemia, hypercalcemia, hypercalciuria PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Hour 19 Month, Day, Year e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 6, 1962 to April 18, 1962 that 10 (we) last saw the deceased alive on April 18, 1962 , and that death occurred at 3:00 P.M., from the causes and on the date stated above.	
22a. SIGNATURE Richard S. Rivlin		22b. DATE SIGNED April 18, 1962	
22c. PHYSICIAN'S NAME (Type) Richard S. Rivlin, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/23/62	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Arlington Va.		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Halley's Funeral Home		25. REC'D BY REGISTRAR APR 24 '62	
26. REGISTRAR'S SIGNATURE James A. [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be completed by the hospital or attending physician. Part 2 may be completed by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04748
MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>4611 High Street</u>	
3. NAME OF DECEASED (Type or print) <u>Michael Gordon Kelly</u>		4. DATE OF DEATH <u>April 29 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 21, 1959</u>
9. AGE (In years last birthday) <u>2 1/2 yrs.</u>		10. AGE (In years last birthday) <u>2 1/2 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Arnold Kelly</u>		14. MOTHER'S MÄDEN NAME <u>Carolyn Keyser</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>(Carolyn Kelly) mother same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Massive intraabdominal hemorrhage</u> DUE TO <u>Rupture, large - liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Auto Accident</u> DUE TO <u>Fracture left femoral shaft - bone</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) <u>Ran over by auto in driveway at home</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year. <u>11:50 a.m. 4-29 1962</u>		20d. INJURY OCCURRED <u>Home</u> 20e. PLACE OF INJURY (Home, farm, factory, school, office bldg, etc.) <u>Cherry Chase Monty Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broscham</u>		DATE SIGNED <u>4-29-62</u>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCAM</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-2-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl. Cem.</u>		22d. LOCATION (City, town, or country) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR <u>W. Don DeVol</u>		24a. REC'D BY REGISTRAR <u>2 1962</u>	
24b. REGISTRAR'S SIGNATURE <u>W. Don DeVol</u>		24c. DATE <u>4-29-62</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04750

CERTIFICATE OF DEATH

04749

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in <u>MD</u> <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> d. STREET ADDRESS <u>13503 Grenoble Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Edwin</u>		4. DATE OF DEATH <u>April 23, 1962</u>		5. SEX <u>Male</u>									
6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/10/10</u>									
9. AGE (In years IF UNDER 1 YEAR, last birthday) <u>52</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table>		Months	Days	Hours	Min.					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>		11. BIRTHPLACE (County & State or foreign country) <u>Missouri</u>	
Months	Days	Hours	Min.										
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Edwin Grattan Kerans</u>		14. MOTHER'S MAIDEN NAME <u>Belle Kitchell</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>Marines</u>		16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT <u>daughter, Mary Ellen Kerans, same as above</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a). <u>myocardial infarction</u> (b). <u>coronary atherosclerosis</u> (c). <u>coronary arteriosclerosis</u> PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).													
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER). 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)													
21. I certify that (I) (this hospital) attended the deceased from <u>2/1/58</u> to <u>4/23/62</u> that (I) (we) last saw the deceased alive on <u>4/23/1962</u> and that death occurred at <u>8:30 AM</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>Dr. Stephen Jones</u> 22c. PHYSICIAN'S NAME (Type) <u>Dr. Stephen Jones</u>													
22b. DATE SIGNED <u>4/23/62</u> 22d. ADDRESS <u>Rockville, Maryland</u>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/25/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>									
23d. LOCATION (City, town or county) (State) <u>Silver Spring, Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Doherty</u>		25a. REC'D BY REGISTRAR <u>APR 26 '62</u>									
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. Brochart notified



TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7, 61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04751
04750
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>UPSHUR - SANTAGUIDA MEDICAL HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission) e. STATE <u>Maryland</u> f. COUNTY <u>Prince Georges</u> g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> h. STREET ADDRESS <u>8206 Roanoke Avenue</u> i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>-</u> Last <u>KERR</u>	4. DATE OF DEATH Month <u>4</u> Day <u>21</u> Year <u>1962</u>	5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Month <u>11</u> Day <u>2</u> Year <u>1902</u>	9. AGE (In years last birthday) yrs. <u>60</u> IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Program Director, Prince Georges Hospital</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Prince Georges, Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas E. Kerr</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Ann Kerr</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>CHART</u> Address <u>-</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>162.0</u> DUE TO <u>Hyaline membrane disease</u> Conditions, if any, which gave rise to immediate cause (b) <u>atelectasis both lungs</u> (c) <u>-</u> DUE TO <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>-</u>										INTERVAL BETWEEN ONSET AND DEATH <u>-</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>							
20c. TIME OF INJURY Hour <u>-</u> a.m. <u>-</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>		20f. (City or town) <u>-</u> (County) <u>-</u> (State) <u>-</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <u>4/21</u> to <u>4/21</u> , 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>4/21</u> , 19 <u>62</u> , and that death occurred at <u>6</u> p.m. from the causes and on the date stated above.										22b. DATE SIGNED <u>4/22/62</u>	
22a. SIGNATURE <u>Herbert H. Diamond</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. PHYSICIAN'S NAME (Type) <u>Herbert H. Diamond</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-23-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Francis</u>		23d. LOCATION (City, town or county) <u>Prince Georges</u> (State) <u>Md.</u>		25a. REC'D BY REGISTRAR <u>Arthur Walter</u> DATE <u>APR 24 '62</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walter</u> ADDRESS <u>214 Carroll St. - No.</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur Walter</u>		25c. REGISTRAR'S SIGNATURE <u>Arthur Walter</u>					

6394

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be filed by the hospital or attending physician. Pages 3 and 4 may be filed by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04751

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>1 day 16 1/2 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>10800 Georgia Ave. Apt. 1</u>	
3. NAME OF DECEASED (Type or print) <u>William Roy Kerr</u>		4. DATE OF DEATH Month Day Year <u>April 24 1962</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Month Day Year <u>January 13 1890 72 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Print. Office</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Stanley Kerr</u>		14. MOTHER'S MAIDEN NAME <u>Victoria Sullinger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-38-8731</u>	
17. INFORMANT <u>Ora M. Kerr</u>		18. ADDRESS <u>10,800 Georgia Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO (b) <u>arterial hypertension</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/22</u> , 19 <u>62</u> to <u>4/24</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>4/23</u> , 19 <u>62</u> , and that death occurred <u>6:00 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Daniel B. Washington</u> M.D.		22b. DATE SIGNED <u>4/24/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Daniel B. Washington MD</u>		22d. ADDRESS <u>6234 G4 Ave. N.W. Wash. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-26-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park, Inc</u>		23d. LOCATION (City, town or county) (State) <u>Falls Church Fairfax Co., Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		25a. REC'D BY REGISTRAR <u>APR 27 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>		25c. ADDRESS <u>Warner E. Humphrey, Inc Silver Spring, Maryland</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04752

1
FOR STATE HEALTH DEPT.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN IL MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6701 Wilson Lane				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 6701 Wilson Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EDWARD W. KIBBEY		4. DATE OF DEATH April 12, 1962		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 13, 1892		9. AGE (In years last birthday) 69 yrs		10. IF UNDER 1 YEAR 11 Months 29 Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Thomas E. Kibbey				14. MOTHER'S M.A.DEN NAME Lillian Feftwich			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW 1				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Wife Dorothy C. Kibbey				18. Address Same as Item 2.			
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Coronary Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1-2-0-1 (b) Coronary Occlusion (c) Coronary Insufficiency				INTERVAL BETWEEN ONSET AND DEATH Sudden Weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I							
19. WAS A JTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. BROSCART				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED April 12, 1962			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/16/62		22c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR Robert A. Pumphrey, Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE APR 17 1962		24b. REGISTRAR'S SIGNATURE Arthur S. K...	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the pages are missing, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

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MEDICAL CERTIFICATION

MONTGOMERY COUNTY, MARYLAND											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04753											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Georgian Hotel 7990 Georgia Ave.</u>				d. STREET ADDRESS <u>2801 Sheraton St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Frank Matthew Kiefer</u>				4. DATE OF DEATH <u>Apr 15 1962</u>				5. SEX <u>m</u>			
6. COLOR OR RACE <u>white</u>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>5-10-25</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>bookbinder</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gov't printing office</u>				11. BIRTHPLACE (State or foreign country) <u>New York</u>			
13. FATHER'S NAME <u>Frank M. Kiefer, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Anna McCabe</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes WWII</u>				16. SOCIAL SECURITY NO. <u>578-22-3117</u>				17. INFORMANT <u>Mrs. Caroline S. Kiefer 3225 Medway St., S.S., Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage & laceration</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bullet wound in rt skull</u> DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Self-inflicted bullet wound in rt skull</u>											
20c. TIME OF INJURY Month, Day, Year <u>10:30 p.m. 4-15 1962</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>hotel</u>			
20f. (City or town) <u>Silver Spring</u>				20g. (County) <u>Monty</u>				20h. (State) <u>md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschatt</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>April 15 1962</u>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschatt</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or country) <u>8434 Georgia Ave.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4-18-62</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery Arlington, Virginia</u>			
23. FUNERAL DIRECTOR <u>Raymond A. Ziska</u>				24a. REC'D BY REGISTRAR <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>Archie L. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04754
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN 1b 19 min. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X Gaithersburg Rural Rt. #2 d. STREET ADDRESS Rural Rt. #2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BABY BOY KING		4. DATE OF DEATH Month 4 Day 9 Year 19 62	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-9-62
9. AGE (In years last birthday) 19		10. IF UNDER 1 YEAR: Months 19 Days 19 Hours 19 Mins. 19	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		11b. KIND OF BUSINESS OR INDUSTRY none	
11c. BIRTHPLACE (County & State, or foreign country) Montgomery, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Willard B King		14. MOTHER'S MAIDEN NAME Agnes Louise Ward	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT hospital records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) atelectasis lungs Conditions, if any, which gave rise to immediate cause (b) Prematurity and Immaturity (a), stating the underlying cause last. (c) Due to PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/9/62 19... to 4/9/62 19..., that (I) (we) last saw the deceased alive on 4/9/62 19..., and that death occurred 8:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE G. F. Meadors 22c. PHYSICIAN'S NAME (Type) G. F. MEADORS, M.D.		22b. DATE SIGNED 4/10/62 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS DAMASCUS, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-11-62	
23c. NAME OF CEMETERY OR CREMATORY Church of Brethern Address Laytonsville, Md.		23d. LOCATION (City, town or county) (State) Redland, Mont. Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber		25a. REC'D BY REGISTRAR APR 13 '62 25b. REGISTRAR'S SIGNATURE William E. Thomas	

5233

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be completed by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04756 CERTIFICATE OF DEATH 04755

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chevy Chase, d. STREET ADDRESS 3616 Taylor Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Allen King		4. DATE OF DEATH April 6, 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 August 1911
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail carrier		11. BIRTHPLACE (County & State, or foreign country) District of Columbia	
13. FATHER'S NAME Raymond W. King		14. MOTHER'S MAIDEN NAME Margaret V. Cocker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 577-20-9950	
17. INFORMANT The Medical Record,		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage from recurrent carcinoma of larynx DUE TO Epid ermoid carcinoma of the larynx CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 days 2 1/2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (he (this hospital) attended the deceased from April 3, 1962 to April 6, 1962 , that (he (we) last saw the deceased alive on April 6, 1962 , and that death occurred 12:15 PM from the causes and on the date stated above.			
22a. SIGNATURE Robert H. Wilkins		22b. DATE SIGNED 4-6-62	
22c. PHYSICIAN'S NAME (Type) Robert H. Wilkins, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/10/62	
23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town or county) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE APR 13 '62	
		25b. REGISTRAR'S SIGNATURE Arthur S. Hays	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

M

04757

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04756

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY in lb 2 1/2 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington
d. STREET ADDRESS 10612 Wheatley St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
First Verna Middle L. Last Kipps

4. DATE OF DEATH April 16, 1962

5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 8. DATE OF BIRTH 3/15/86 9. AGE (in years last birthday) 76 yrs. IF UNDER 1 YEAR Months Days Hours Mins. IF UNDER 24 HRS. Months Days Hours Mins.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles M. Ingram 14. MOTHER'S MAIDEN NAME Mary Jane Montgomery

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No 16. SOCIAL SECURITY NO. 577-09-21834 17. INFORMANT Charles A. Kipps - Son - Home Address Montgomery

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Thrombosis, left middle cerebral artery
(b) Arteriosclerosis, cerebral
(c) Arteriosclerosis general
DUE TO Arteriosclerosis
DUE TO Arteriosclerosis
DUE TO Arteriosclerosis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis (b) Arteriosclerosis (c) Arteriosclerosis
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Arteriosclerosis Arteriosclerosis Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) (County) (State) Bethesda Montgomery Maryland

21. I certify that (I) (the hospital) attended the deceased from MARCH 1953 to APRIL 16, 1962, that (I) (the hospital) last saw the deceased alive on APRIL 15, 1962, and that death occurred at 8:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE Robert G. Angle 22b. DATE SIGNED 4/16/62
22c. PHYSICIAN'S NAME (Type) Robert G. Angle 22d. ADDRESS DelRay Avenue, Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 4/18/62 23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery 23d. LOCATION (City, town or county) (State) Rockville, Maryland Maryland

24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland ADDRESS 25a. REC'D BY REGISTRAR APR 19 1962 25b. REGISTRAR'S SIGNATURE Robert A. Pumphrey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached and filed by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04758
04757
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN <u>MD</u> <u>36 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> d. STREET ADDRESS <u>29 Quincey St.</u>	
3. NAME OF DECEASED (Type or print) <u>IRENE S. KIRKWOOD</u>		4. DATE OF DEATH Month <u>4</u> Day <u>28</u> Year <u>1962</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/28/84</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>1</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>	
13. FATHER'S NAME <u>Morgan Sherwood</u>		14. MOTHER'S MAIDEN NAME <u>Maria Hurdle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>daught - Jean White</u>	
17. INFORMATION <u>daughter - Jean White</u>		18. INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1</u> DUE TO <u>congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>434.1</u> (a), stating the underlying cause last (c) <u>434.1</u> DUE TO <u>congestive heart failure</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>434.1</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <u>19</u>			
20d. INJURY OCCURRED White of work <input type="checkbox"/> Not White of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1957</u> to <u>27 Apr 1962</u> that (I) (we) last saw the deceased alive on <u>27 Apr 1962</u> and that death occurred at <u>4:15 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Herbert Martyn Jr</u>			
22b. DATE <u>28 Apr 62</u>			
22c. PHYSICIAN'S NAME (Type) <u>HERBERT MARTYN JR</u>			
22d. ADDRESS <u>4740 Cherry Chase Dr</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>4-30-1962</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>			
23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gaudin</u>			
25a. REC'D BY REGISTRAR <u>May 2 '62</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>			

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>1817 Reedie Drive</u>	
3. NAME OF DECEASED (Type or print) <u>MORRIS</u> First <u>KOBAK</u> Middle Last		4. DATE OF DEATH <u>April 22</u> Month Day Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/15/85</u>
9. AGE (In years lost birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. BIRTHPLACE (State or foreign country) <u>Austria</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Samuel Kobak</u>	
14. MOTHER'S MAIDEN NAME <u>Esther Weisner</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO <u>UNKNOWN</u>		17. INFORMANT <u>MRS Sally Puglin</u> Address <u>1817-REEDIE Dr. S S. Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR COLLAPSE</u> <u>1810</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>POST-OPERATIVE FROM SURGERY</u> DUE TO (c) <u>CARCINOMA OF BLADDER</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>5 days</u> <u>MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/21</u> , 19 <u>62</u> , to <u>4/22</u> , 19 <u>62</u> that I last saw the deceased alive on <u>4/21</u> , 19 <u>62</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>M.D. 1015 SPRING ST, SILVER SPRING, MD</u> DATE SIGNED <u>1962</u>			
ACTUAL SIGNATURE <u>Arthur J. Willets</u>		PHYSICIAN'S NAME (Type) <u>ARTHUR J. WILETS</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/23/62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ind. Heb. Soc. Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Norwalk, Conn.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danzansky & Sons</u> ADDRESS <u>Wash. D.C.</u>		24. REGISTRAR'S SIGNATURE <u>Arthur J. Willets</u>	25. REC'D BY REGISTRAR DATE <u>APR 24 1962</u>

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The funeral director, or attending physician, may be relieved of this requirement by the health officer. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, or attending physician, may be relieved of this requirement by the health officer. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04759

04760

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda, Md. c. LENGTH OF STAY IN TB 6 mos.		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda, Maryland d. STREET ADDRESS 5602 Pollard Rd.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Nellie B. Lamb		4. DATE OF DEATH Month Day Year April 14, 1962			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Dec. 25, 1887		9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Sidney I. Besselievre		14. MOTHER'S MAIDEN NAME Nellie Ecker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Son, Wm. Ers Lamb, Jr. (Same as above)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary Occlusion 420 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sudden DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 4-14-62 Address (Street, city, town, or county)					
ACTUAL SIGNATURE Frank J. Broschant		EXAMINER'S NAME (Type) FRANK J. Broschant			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 4-16-62		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	
22d. LOCATION (City, town, or county) (State) Suitland, Maryland					
23. FUNERAL DIRECTOR ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 4-14-62	
24b. REGISTRAR'S SIGNATURE Curtis L. Kline					

MEDICAL CERTIFICATION

2

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. AISME
SM 9/60

04761
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN 1b <u>5 yrs</u>		d. STREET ADDRESS <u>907 Wesley Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>907 Wesley Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Kern Lambert</u>		4. DATE OF DEATH <u>Apr 20 1962</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-2-24</u>
9. AGE (In years last birthday) <u>37</u> yrs.		10. AGE (In years last birthday) <u>37</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>	
11. BIRTHPLACE (State or foreign country) <u>Tenn</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Redford Lambert</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Powell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW II</u>		16. SOCIAL SECURITY NO. <u>411 20 6223</u>	
17. INFORMANT <u>Janet Lambert (wife)</u>		Address <u>Stur 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420 c 1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, lectory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 23 62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		22d. LOCATION (City, town, or country) <u>Rockville Md.</u>	
23. FUNERAL DIRECTOR <u>Francis H. Barber</u>		24a. REC'D BY REGISTRAR <u>APR 24 '62</u>	
ADDRESS <u>Laytonsville, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

04760

MEDICAL CERTIFICATE

CERTIFICATE OF DEATH

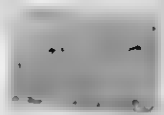
04762

04761

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 17 days		2. USUAL RESIDENCE (Where deceased lived, if last before adm ssion) a. STATE Florida		b. COUNTY		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) U. S. Naval Vase, Key West		d. STREET ADDRESS 1063 Halsey Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Hamilton Langton		4. DATE OF DEATH April 7, 1962		5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 12, 1923		9. AGE (in years last birthday) 38 yrs.		10. IF UNDER 1 YEAR, Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Officer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Thomas Langton		14. MOTHER'S MAIDEN NAME Aldeliade Jones		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Mary Jane Langton	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myeloid Leukemia 20. DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a), 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 months		21. I certify that (X) (this hospital) attended the deceased from March 21, 1962 to April 7, 1962 , that (X) (we) last saw the deceased alive on April 7, 1962 , and that death occurred 2:10 PM from the causes and on the date stated above		22a. SIGNATURE Charles E. Brodine		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Charles E. Brodine, LCDR USN (MC)		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-10-62		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia		24. FUNERAL DIRECTOR'S SIGNATURE Chambers Funeral Home, 8655 Georgia Ave.		25a. REC'D BY REGISTRAR APR 12 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Hines		25c. ADDRESS	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. The death certificate is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

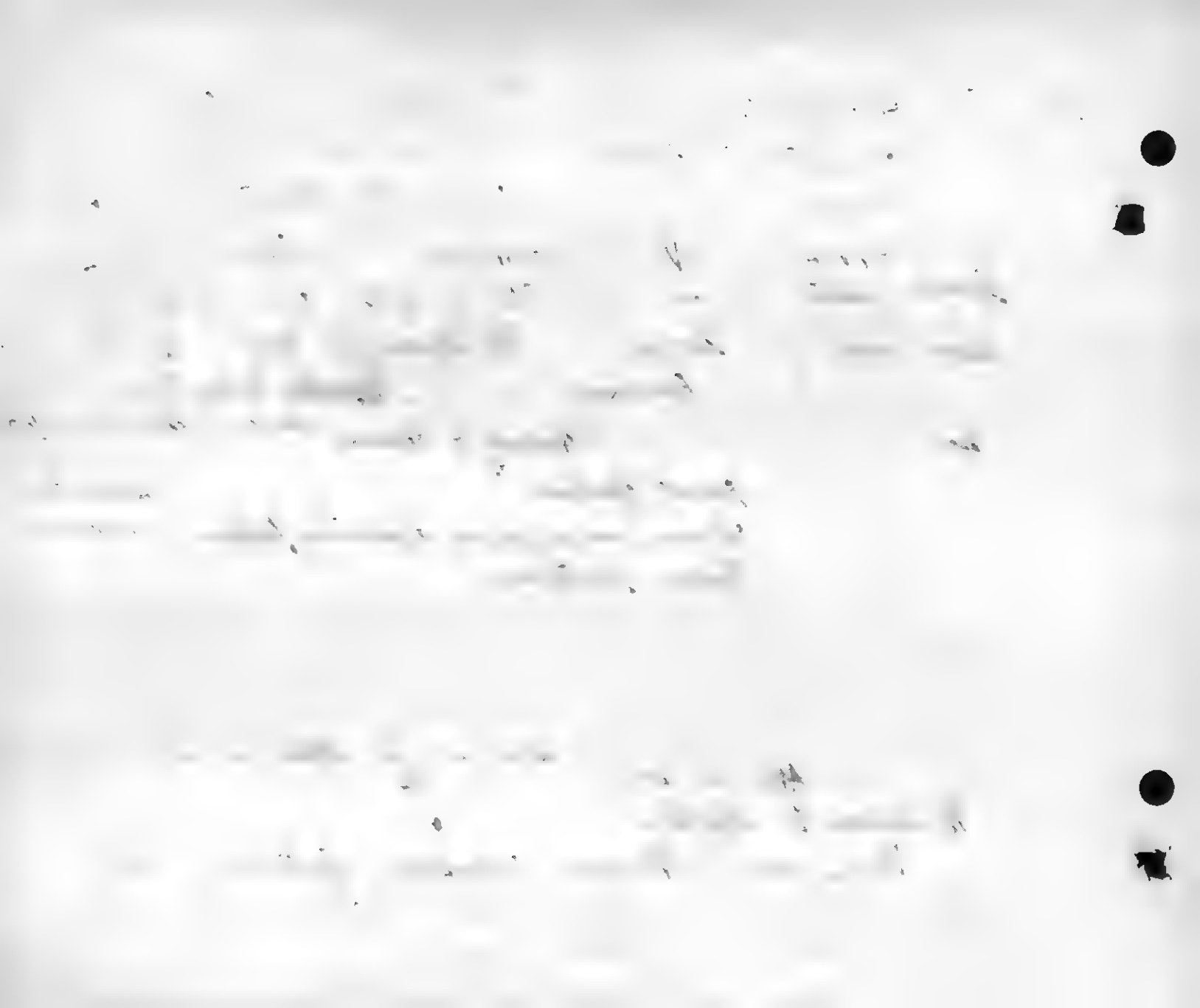
04762		Item 230, Film 6311 4/12/62 ink		04762	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY in lb <u>D.O.A.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>1958 Rosemary Hills Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>K.</u> Last <u>Lawless</u>		4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1962</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>8/10/10</u>		9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wage Spec.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Govt.</u>		11. BIRTHPLACE (County & State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JOSEPH THOMAS LAWLESS</u>		14. MOTHER'S MAIDEN NAME <u>MARIE ANTILOTTI</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES 1943-45</u>		16. SOCIAL SECURITY NO. <u>225 07 083</u>		17. INFORMANT <u>Miss Theodora Krout, friend</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>42-1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Coronary sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>Several years</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>		20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 20</u> , 19 <u>61</u> , to <u>April 4</u> , 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>4/4</u> , 19 <u>62</u> , and that death occurred at <u>1:15</u> P.M., from the causes and on the date stated above.					
22a. SIGNATURE <u>Max G. Sherer</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/4/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>MAX G. SHERER MD</u>		22d. ADDRESS <u>2025 EAST West H'way Silver Spring Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/9/1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>	
23d. LOCATION (City, town or county) <u>Arlington, Virginia</u>		23e. REC'D BY REGISTRAR <u> </u>		23f. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Thomas</u>		ADDRESS <u>201 N. FAIRFAX DRIVE ARLINGTON 3, VA</u>			

CERTIFICATE OF DEATH

04764

04763

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germanstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rural</u>		d. STREET ADDRESS <u>East 13th Street</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>OLIVIA</u> First Middle Last <u>LAWSON</u>		4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1962</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct-7-1886</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>6</u> Days <u>18</u> Hours <u>—</u> M. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, when if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (State or foreign country) <u>Montgomery Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Harrison</u>		14. MOTHER'S MAIDEN NAME <u>Cornelia Martha W. Harten</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-34-060</u>	
17. INFORMANT <u>Andrew F. Himes</u> Address <u>Route 1, Monrovia, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>422.2</u> DUE TO <u>Chronic myocardial degeneration, Refractive</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic asthma</u> (c) <u>Chronic asthma</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u> <u>unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec-4-</u> , 19 <u>61</u> , to <u>April-25-</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>April-22-1962</u> , and that death occurred at <u>12 M.</u> from the causes and on the date stated above			
22a. SIGNATURE <u>William C. Miller</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM C. MILLER</u>		22d. ADDRESS <u>7 Brook Ave., Gaithersburg, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-28-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hyalakston Lutheran Ch</u>	23d. LOCATION (City, town or county) (State) <u>Hyalakston Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Farkner</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u> DATE <u>APR 30 '62</u>	
25b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

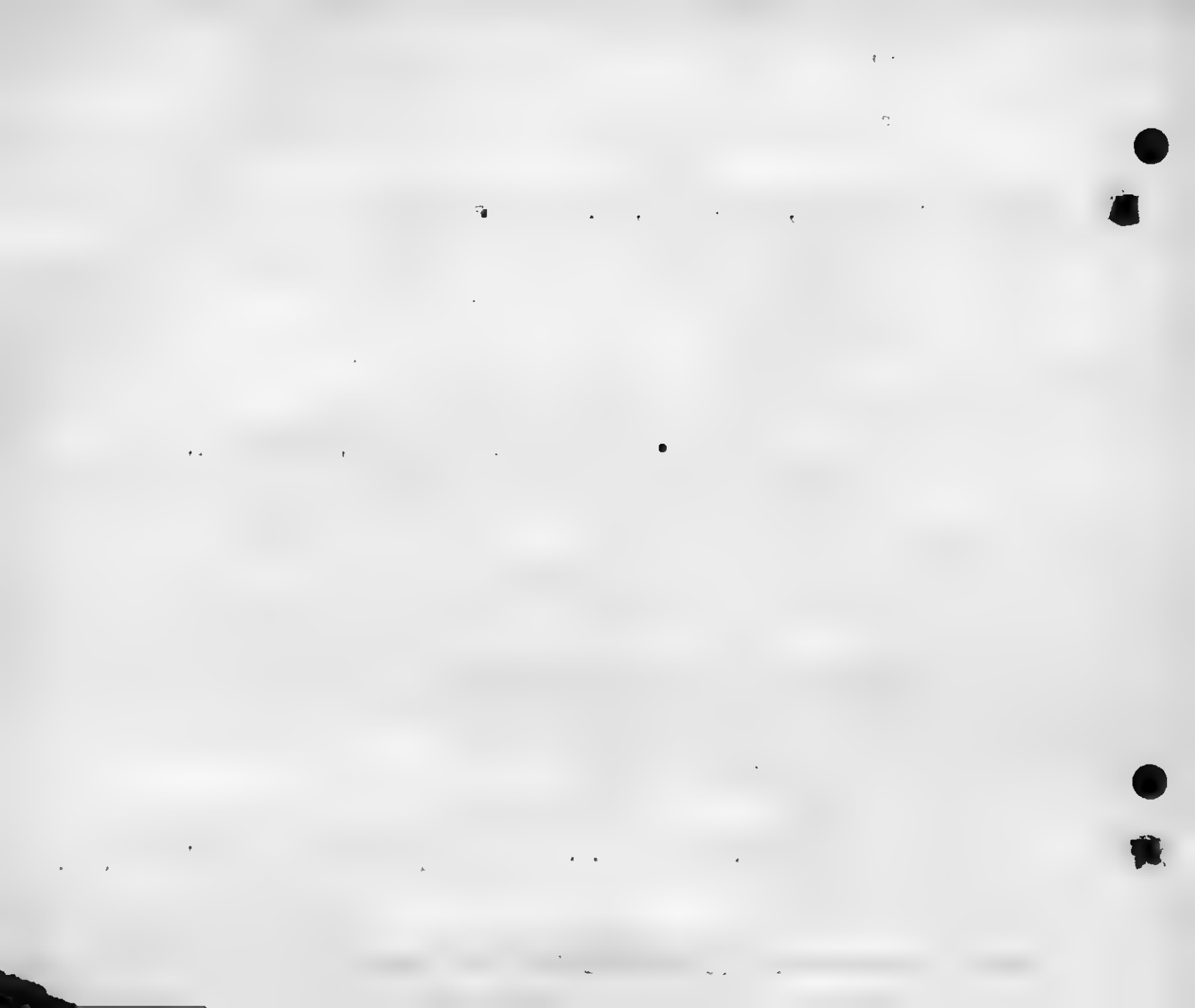
CERTIFICATE OF DEATH

04765

04764

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN (b) <u>14</u> days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Rhoads</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Post Office Box 207</u> d. STREET ADDRESS <u>Post Office Box 207</u>	
3. NAME OF DECEASED (Type or print) First <u>Eric</u> Middle <u>Jon</u> Last <u>Lehrman</u>		4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>1962</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>6 April 1955</u>		9. AGE (In years IF UNDER 1 YEAR; IF UNDER 24 HRS. last birthday) Months <u>7</u> Days <u>23</u> Hours <u>11</u> Min <u>25</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Curtis Lehman</u>	
14. MOTHER'S MAIDEN NAME <u>Janice Weaver</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> (c) <u>Cystic Fibrosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>Months</u> <u>7 Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>11:25AM</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XX (this hospital) attended the deceased from <u>APRIL 11</u> , 19 <u>62</u> to <u>April 23</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>April 23</u> , 19 <u>62</u> , and that death occurred at <u>11:25AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Daniel V. Kimberg</u>		22b. DATE SIGNED <u>4/23/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Daniel V. Kimberg M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL <u>BURIAL</u>		23b. DATE THEREOF <u>4/24/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ELIZABETHTOWN PA.</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W W Chambers Co., 1400 Washington St NW, Washington DC</u>		25a. REC'D BY REGISTRAR <u>APR 25 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Brand</u>			

VR A15 (4)
15M 9/60



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

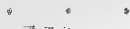
04766

04765

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>2 1/2 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. Saw + Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Wash D.C.</u> b. COUNTY <u>D.C.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wash. D.C.</u> d. STREET ADDRESS <u>5013 14th St. N.W. Wash, D.C.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Leibert Joseph Matthias Leibert</u> First Middle Last		4. DATE OF DEATH Month <u>4</u> Day <u>27</u> Year <u>1962</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>5-16-1873</u> 9. AGE (In years last birthday) <u>88</u> yrs. IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> IF UNDER 24 HRS. Hours <u>11</u> Min. <u>11</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Potomac Power Co. - Chief Clerk</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Pa.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U. S. A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Richard W. Leibert</u> 14. MOTHER'S MAIDEN NAME <u>Roberta S. Leibert Maria Krauss</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) <u>no</u> 16. SOCIAL SECURITY NO. <u>577-05-0821</u> 17. INFORMANT <u>Records of Wash. Saw + hosp.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis, generalized</u> (c) <u>10 yrs</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>5 days</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20c. TIME OF INJURY Hour <u>19</u> m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> <u>1954</u> to <u>Apr. 27</u> <u>1962</u> , that (I) (we) last saw the deceased alive on <u>Apr. 27</u> <u>1962</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>John Lawrence Avery</u> 22c. PHYSICIAN'S NAME (Type) <u>John Lawrence Avery</u> 22d. ADDRESS <u>10110 Georgia Ave. Silver Spring Md.</u>		22b. DATE SIGNED <u>4/27/62</u> 25a. REC'D BY REGISTRAR <u>APR 30 1962</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>5/1/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Nisky Hill Cemetery</u> 23d. LOCATION (City, town or county) <u>Bethlehem, Pennsylvania</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>W.H. HINES Co.</u> 25a. REC'D BY REGISTRAR <u>APR 30 1962</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: This certificate is to be retained by the hospital or funeral home for 4 months after the death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director's office, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04767

CERTIFICATE OF DEATH

04766

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN b. 2 1/2 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 420 Kerwin Road		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 420 Kerwin Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Russell Lent		4. DATE OF DEATH April 24 1962	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1892
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Director		10b. KIND OF BUSINESS OR INDUSTRY American Gun Dealers BIRTHPLACE New York	
13. FATHER'S NAME Samuel D. Lent		14. MOTHER'S MAIDEN NAME Mary Lee	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 045-03-6101	
17. INFORMANT Mrs. Mabel E. Lent		Address 420 Kerwin Rd, S.S., Md.	
18. CAUSE OF DEATH [Enter on y one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 162.1 DUE TO Bronchiogenic Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 year	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Feb 11, 1960 to April 24, 1962 that (I) (we) last saw the deceased alive on April 24, 1962 and that death occurred at 9:30 A M, from the causes and on the date stated above.			
22a. SIGNATURE John J. Curry		22b. DATE SIGNED 4/24/62	
22c. PHYSICIAN'S NAME (Type) John J. Curry		22d. ADDRESS 10,620 Georgia Ave, Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-26-62	
23c. NAME OF CEMETERY OR CREMATORY Reformed Dutch Church Cemetery		23d. LOCATION (City, town or county) Montrose Westchester Co., New York	
24 FUNERAL DIRECTOR'S SIGNATURE Raymond A. Zohn		25a. REC'D BY REGISTRAR APR 27 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Hines		25c. ADDRESS Warner E. Pumphrey, Inc. Silver Spring, Maryland	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04768 CERTIFICATE OF DEATH 04767

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 32 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE New Jersey b. COUNTY Hudson c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jersey City d. STREET ADDRESS 608 Palisade Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Concetta Mary Letizia		4. DATE OF DEATH April 28, 1962	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 17, 1938	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Letizia		14. MOTHER'S MAIDEN NAME Bessie Ruvalo	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 151-30-5163	
17. INFORMANT The Medical Record		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 7.4.5 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last: DUE TO (b) Cardiac surgery of atrial septal defect DUE TO (c) Cyanotic congenital heart disease (Pulmonic stenosis and atrial septal defect) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)	
19. INTERVAL BETWEEN ONSET AND DEATH 12 hours		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that X (this hospital) attended the deceased from March 27, 1962 to April 28, 1962 , that he (we) last saw the deceased alive on April 28, 1962 , and that death occurred at 5:40AM from the causes and on the date stated above.			
22a. SIGNATURE James L. Talbert		22b. DATE SIGNED 4/28/62	
22c. PHYSICIAN'S NAME (Type) James L. Talbert, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
Burial-transit 4-28-62		Arlington Cemetery Bergen County, New Jersey	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR MAY 4 '62	
ADDRESS Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04769 CERTIFICATE OF DEATH 04768

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville
c. LENGTH OF STAY IN IL D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban

2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)
a. STATE md. b. COUNTY Mont. Co.
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville
d. STREET ADDRESS 917 Crawford Drive

3. NAME OF DECEASED (Type or print) Carrie Burns Lytton
First Middle Last
4. DATE OF DEATH April 14 1962
Month Day Year

5. SEX male 6. COLOR OR RACE white 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH April 25, 1889 72 yrs.
WIDOWED ☐ DIVORCED ☐ 9. AGE (In years, last birthday) If UNDER 1 YEAR: Months Days If UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired in water control government 10b. KIND OF BUSINESS OR INDUSTRY Virginia 11. BIRTHPLACE (County & State, or foreign country) U.S.A.
12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME Zachariah Taylor 14. MOTHER'S M maiden name Becca Vermillion

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no 16. SOCIAL SECURITY NO. 214-12-7261 17. INFORMANT Balfour Lytton Address 53rd Ave Above

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive retroperitoneal hemorrhage 1 hr.
(b) Ruptured aneurysm of abdominal aorta 1 hr.
(c) Atherosclerosis severe of aorta years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) Pul. TBC.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 4/17/62 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town, (County) (State)

21. I certify that (I) (This hospital) attended the deceased from 4/13/62 to 4/17/62, that (I) (we) last saw the deceased alive on 4/13/62 and that death occurred at 3:00 P.M. from the causes and on the date stated above.

22a. SIGNATURE Stephen R. Jones 22b. DATE SIGNED 4/15/62
22c. PHYSICIAN'S NAME (Type) Stephen R. Jones 22d. ADDRESS Rockville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 4/17/62 23c. NAME OF CEMETERY OR CREMATORY Parklawn 23d. LOCATION (City, town or county) (State) Rockville, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE John P. ... ADDRESS ... 25a. REC'D BY REGISTRAR DATE APR 18 '62 25b. REGISTRAR'S SIGNATURE Arthur S. ...

TO HOSPITAL OR FUNERAL DIRECTOR: This law requires that the death certificate be executed within 72 hours after death. The 4 m. retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04770

04769

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington - San. Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md.</u> d. STREET ADDRESS <u>1406 W. 1st St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Christopher May 908</u> First Middle Last				4. DATE OF DEATH <u>4 - 5 1962</u> Month Day Year					
5. SEX <u>M</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-16-92</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>auditor</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Employer</u>				9. AGE (In years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Christopher May</u>				14. MOTHER'S MAIDEN NAME <u>Annie Obrey</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u> 17. INFORMANT <u>Address</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Left Parotitis & septicemia</u> DUE TO (b) <u>Post-op. proctectomy</u> DUE TO (c) <u>Adenocarcinoma of prostate</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>6 "</u> <u>?</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 18) <u>no</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from... <u>3/28 1962</u> , to <u>4/5 1962</u> , that (I) (we) last saw the deceased alive on <u>4/5 1962</u> , and that death occurred at <u>105 P.M.</u> from the causes and on the date stated above									
22a. SIGNATURE <u>Joseph Bloom</u> 22c. PHYSICIAN'S NAME (Type) <u>Joseph Bloom, M.D.</u>				22b. DATE SIGNED <u>4/6/62</u> 22d. ADDRESS <u>8110 15 Spring Silver Spring Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-2-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Bladensburg, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Real Funeral Home, Wash D.C.</u>				25a. REC'D BY REGISTRAR <u>APR 11 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>					

TO HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death.



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04771

04770

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE _____ b. COUNTY _____			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7701 R. Stern Avenue Apt. #201</u>				d. STREET ADDRESS <u>3150 16th St., N.W.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lelia Sophie Manning</u>				4. DATE OF DEATH Month Day Year <u>April 26 1962</u>			
5. SEX <u>female</u>				6. COLOR OR RACE <u>white</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>March 20, 1908</u>				9. AGE (In years; if UNDER 1 YEAR, if UNDER 24 HRS., list birthday) Months Days Hours Min. <u>54 yrs.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>lab. clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>shoe store</u>			
11. BIRTHPLACE (County & State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Robert L. Annadale</u>				14. MOTHER'S MAIDEN NAME <u>Marsha Nash</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>57-05-7904</u>			
17. INFORMANT <u>John Tarkenton</u>				Address <u>Linthicum Hgts., Md. 560 Fairmont Pk.</u>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420 - 1</u> DUE TO <u>Acute Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>unknown</u> (c) <u>unknown</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Broncho Pneumonia</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) (If EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>at home</u>		20f. (City or town) (County) (State) <u>4/26/62</u>	
21. I certify that (I) (this hospital) attended the deceased from... 4/24/62 ... to 4/26/62 ... that (I) (we) last saw the deceased alive on... 4/26/62 8 P.M. ... and that death occurred at... M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Arthur A. Davis</u>				22b. DATE SIGNED <u>4/26/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR A. DAVIS</u>				22d. ADDRESS <u>8200 - 16th St. ST 26-672 St. R. L.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-30-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges Co., Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond C. Zisk</u>				25. REC'D BY REGISTRAR <u>APR 30 '62</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04772

04771

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town, Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		d. STREET ADDRESS 5615 Southwick Street	
3. NAME OF DECEASED (Type or print) SYDNEY		4. DATE OF DEATH April 13, 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 12, 1918
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Watch Company	
11. BIRTHPLACE (County & State, or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Harry Marks		14. MOTHER'S MAIDEN NAME Katie Epstein	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 134-09-9889	
17. INFORMANT Wife		Address Same as Item #2	
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Gastric cancer, benign orthopaedic 2044-3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Pericarditis DUE TO Acute leukemic (myeloblastic)		INTERVAL BETWEEN ONSET AND DEATH 1 Hour 3 hrs 4 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 10, 1962 to April 13, 1962 that (I) (we) last saw the deceased alive on April 10, 1962 , and that death occurred at 11:45 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Arnold Lear		22b. DATE SIGNED 4-14-62	
22c. PHYSICIAN'S NAME (Type) ARNOLD LEAR		22d. ADDRESS 1302 18th St. N.W. Washington, D.C.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 4/17/62	
23c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey		25a. REC'D BY REGISTRAR 11:45 25b. REGISTRAR'S SIGNATURE W. J. ...	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

FOR STATE
HEALTH DEPT.

M

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2

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04773

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>1701 MERRIMAC DRIVE</u>	
3. NAME OF DECEASED (Type or print) <u>MRS. FRIEDA ELIZABETH MAYERHOFER</u>		4. DATE OF DEATH <u>4 2 1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-19-1891</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. AGE (In years last birthday) <u>70</u> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
13. FATHER'S NAME <u>August Saglitz</u>		12. CITIZEN OF WHAT COUNTRY? <u>Am</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		14. MOTHER'S MAIDEN NAME <u>SELMA URBAN</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Patient's Chart</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>261.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Died suddenly following surgery for repair of hiatal hernia</u>			
20a. EXTERNAL CAUSE OF DEATH PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		DATE SIGNED <u>Apr 3 1962</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		Address (Street, city, town, or county) <u>Southland Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/6/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Southland Md</u>	
23. FUNERAL DIRECTOR <u>W.W. Chambers Co., Silver Spring Md.</u>		24a. REC'D BY REGISTRAR <u>APR 5 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completed. Pages 3 and 4 may be completed by the funeral director. After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

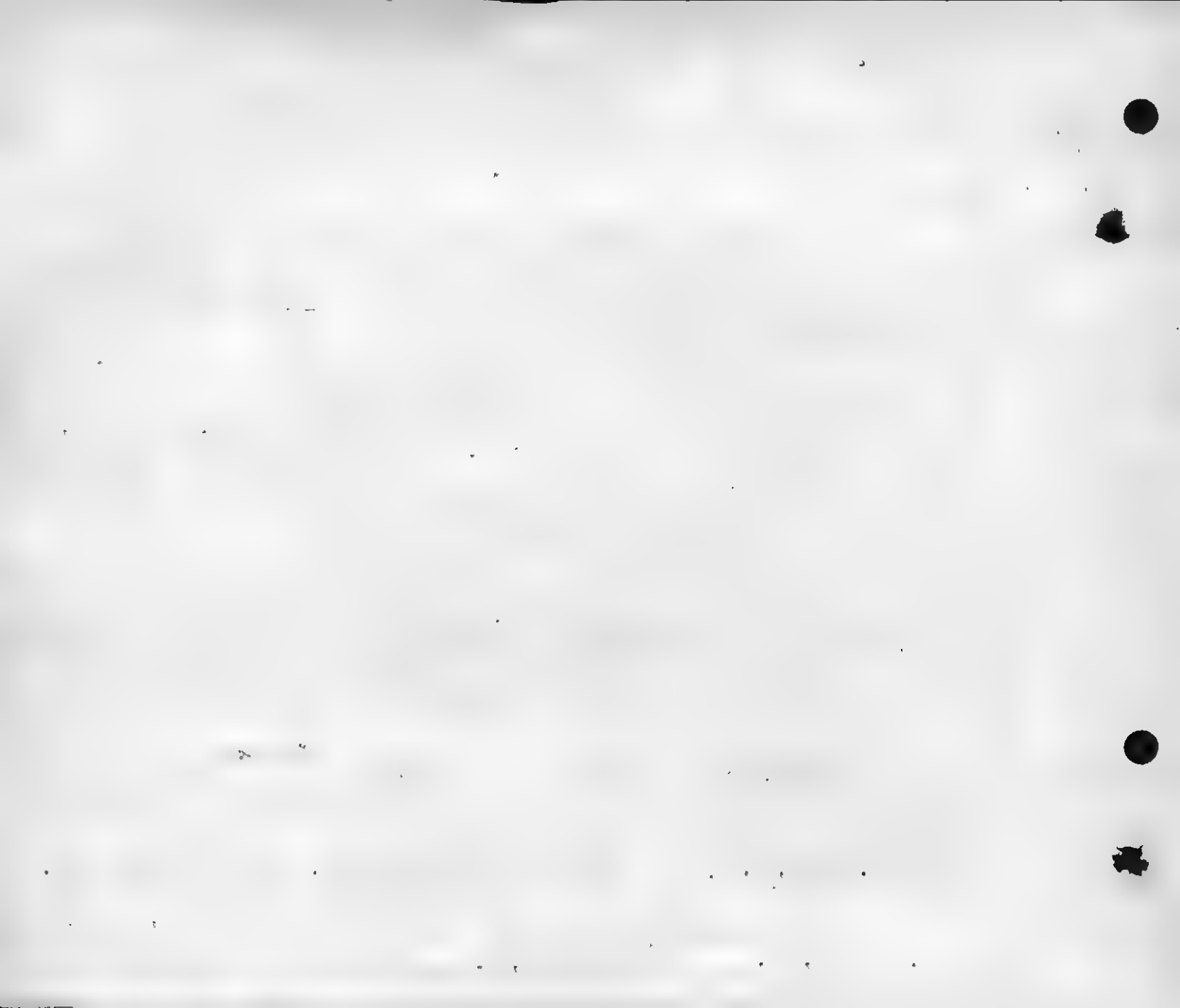
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04775

04774

1. PLACE OF DEATH a. COUNTY <u>Mont. County</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Olney, Md.</u> c. LENGTH OF STAY in 1b <u>6 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SHARON Building</u> e. NAME OF DECEASED (Type or print) <u>Brooke Grove Foundation</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville, Md.</u> d. STREET ADDRESS <u>1351 Langley Way</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Howard F. Mayhew</u> 4. DATE OF DEATH <u>April 3, 1962</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>11-5-1885</u> 9. AGE (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR: Months <u>4</u> Days <u>7</u> IF UNDER 24 HRS.: Hours <u>4</u> Min. <u>47</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Eng.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Eng.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Vineyard Haven Mass. U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Washburn Mayhew</u> 14. MOTHER'S MAIDEN NAME <u>Clara Flanders</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Clara M. Mayhew</u> Address <u>W. Hyattsville, Maryland</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u> DUE TO (b) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Unknown</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>Diffuse pulmonary emphysema bilateral</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town, County, State)		21. I certify that (I) (the hospital) attended the deceased from <u>Dec. 28, 1957</u> to <u>April 3, 1962</u> , that (I) (we) last saw the deceased alive on <u>March 29, 1962</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.	
22a. SIGNATURE <u>Aaron H. Traum</u> 22c. PHYSICIAN'S NAME (Type) <u>Aaron H. Traum, M. D.</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4-5-62</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond J. Warner</u> 25a. REC'D BY REGISTRAR <u>APR 6 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Traut</u>		22b. DATE SIGNED <u>April 3, 1962</u> 22d. ADDRESS <u>8237 Georgia Ave., Silver Spring, Md.</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u> 23d. LOCATION (City, town or county) <u>Prince George's Co., Maryland</u> 25c. REGISTRAR'S SIGNATURE <u>Arthur S. Traut</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and complete pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04776

04775

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 45 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Colorado b. COUNTY Aurora (c/o Antoinette Gardner) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1148 Newark Street d. STREET ADDRESS 44X 3	
3. NAME OF DECEASED (Type or print) John Francis McCabe		4. DATE OF DEATH April 4, 1962	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 19, 1906
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR: Months 5 Days 6 Hours 1 Min. 5	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreign Service Officer		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Francis McCabe		14. MOTHER'S MAIDEN NAME Ellen Calvey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIA. SECURITY NO. - - - -	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia 356-1 Conditions, if any, which gave rise to immediate cause (b) amyotrophic lateral sclerosis (a), stating the underlying cause last. (c)			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 6 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part I of Item 18]	
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 21, 1962 , to April 4, 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 4, 1962 , and that death occurred at 9:55 PM from the causes and on the date stated above			
22a. SIGNATURE Bartholomew T. Hogan M.D.		22b. DATE SIGNED April 5, 1962	
22c. PHYSICIAN'S NAME (Type) BARTHOLOMEW T. HOGAN LT MC USN U. S. Naval Hospital, Bethesda, Md.		22d. ADDRESS	
23a. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> REMOVAL (Specify) Burial	23b. DATE THEREOF 4-9-62	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City, town or county) (State) Arlington, Virginia
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR APR 6 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kious			

1
FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04777

1. PLACE OF DEATH
a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Damascus c. LENGTH OF STAY in 1b 5 yrs

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE md b. COUNTY Montg c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda

3. NAME OF DECEASED (Type or print) Selwyn Otis McCoy 4. DATE OF DEATH Apr 11 1962

5. SEX male 6. COLOR OR RACE white 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 3-4-1919 9. AGE (in years last birthday) 43 yrs. IF UNDER 1 YEAR: Months 0 Days 0 IF UNDER 24 HRS.: Hours 0 Mins. 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) superintendent 10b. KIND OF BUSINESS OR INDUSTRY duftman 11. BIRTHPLACE (State or foreign country) md 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Otis Ellis McCoy 14. MOTHER'S MAIDEN NAME Hortense Herman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. 217-05-1186 17. INFORMANT Dorothy McCoy (wife) Address Stuen 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
DUE TO
Conditions, if any, which gave rise to immediate cause (b) fatal
(c), stating the underlying cause last. due to
DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death
sudden

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Broschert CHIEF MEDICAL EXAMINER ☐ M.D. ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 4-11-62

EXAMINER'S NAME (Type) FRANK J. Broschert Address (Street, city, town, or county) (State)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF April 14, 1962 22c. NAME OF CEMETERY OR CREMATORY Woodlawn 22d. LOCATION (City, town, or country) (State) Baltimore Md.

23. FUNERAL DIRECTOR John L. Molsworth ADDRESS Damascus, Md. 24a. REC'D BY REGISTRAR APR 13 '62 24b. REGISTRAR'S SIGNATURE William S. Kraus

CERTIFICATE OF DEATH

04778

04777

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>13 1/4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> d. STREET ADDRESS <u>3317 - 16th St., N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Grace (N MN) Mc Laurine</u> 4. DATE OF DEATH <u>April 19 1962</u>		5. SEX <u>female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>3/4/1885</u> 9. AGE (In years last birthday) <u>77</u> yrs. 10. IF UNDER 1 YEAR Months _____ Days _____ 11. IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Schools</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Florida</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>George W. Mc Laurine</u> 14. MOTHER'S MAIDEN NAME <u>Malissa Eliza Frayser</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. _____ 17. INFORMANT <u>Hospital Chart</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Splenic (?) hemorrhage</u> (b) <u>Low platelets</u> (c) <u>Subacute Myelogenous Leukemia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____ 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from.. 4-16-1962 to 4-19-1962 that (I) (we) last saw the deceased alive on 4-18-1962 and that death occurred at 2:45 P.M. from the causes and on the date stated above. 22a. SIGNATURE <u>Chas H Volohin</u> 22b. DATE SIGNED _____ 22c. PHYSICIAN'S NAME (Type) <u>Chas H Volohin</u> 22d. ADDRESS _____ 22e. REC'D BY REGISTRAR _____ 22f. REGISTRAR'S SIGNATURE <u>Arthur S. Tinsley</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> 23b. DATE THEREOF <u>4/23/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u> 23d. LOCATION (City, town or county) <u>Washington, D.C.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Tinsley</u> 25a. DATE <u>APR 23 '62</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be completed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

04778

04779

1. PLACE OF DEATH
a. COUNTY MONTGOMERY **MARYLAND**
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BETH-SPA
c. LENGTH OF STAY IN b. 6 1/2 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SUBURBAN

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) GAITHERSBURG
d. STREET ADDRESS Route # 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) MALE
First Middle Last
4. DATE OF DEATH Month Day Year APRIL 25 1962
5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 4/4/85
9. AGE (In years last birthday) 77 yrs.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
11. BIRTHPLACE (County & State, or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Retired
14. MOTHER'S MAIDEN NAME ARA THRIFF
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
16. SOCIAL SECURITY NO. DAUGHTER (Mrs. Helen Wells) #8
17. INFORMANT James St.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
HYPERTENSIVE CARDIOVASCULAR DISEASE
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from MAY 1950 to APRIL 25 1962; that (I) (we) last saw the deceased alive on APRIL 25 1962; and that death occurred at 4:15 PM, from the causes and on the date stated above.
22a. SIGNATURE Dr. Aug. Lawrence D.
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS
22e. REC'D BY REGISTRAR APR 27 '62
22f. REGISTRAR'S SIGNATURE Arthur S. Kraus
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 4/27/62
23c. NAME OF CEMETERY OR CREMATORY Darnestown
23d. LOCATION (City, town or county) (State) Darnestown, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Fycon Wheeler Funeral Home
24a. ADDRESS 1331 West Montgomery
24b. CITY, STATE, ZIP Rockville, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, 4 may be filled in by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04780

CERTIFICATE OF DEATH

04779

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital		e. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Virginia b. COUNTY Falls Church c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church d. STREET ADDRESS 7826 Allen Sturges Terrace e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF (Type or print) Jeane		First Anne		Middle MILLER	
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF DEATH April 15 1962		9. AGE (In years last birthday) 42 yrs.		10. IF UNDER 1 YEAR Months 15 Days 19 Hrs. 62	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Hall County, Nebraska	
13. FATHER'S NAME Oscar Viereggs		14. MOTHER'S MAIDEN NAME Eva Brass		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 175-0 DUE TO A splenification Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. } (b) Wide spread Metastases - Carcinoma (c) AdenoCarcinoma of The Ovary PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 18 mos		INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8 Mar 62 to 15 Apr 62 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 15 1962 , and that death occurred at 2310 pm on the causes and on the date stated above.					
22a. SIGNATURE L.E. Potvin		22b. DATE SIGNED APR 17 '62		22c. PHYSICIAN'S NAME (Type) L.E. POTVIN	
22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial April 21, 1962		23c. NAME OF CEMETERY OR CREMATORY Grand Island Cemetery		23d. LOCATION (City, town or county) (State) Grand Island, Nebraska	
24. FUNERAL DIRECTOR'S SIGNATURE Everly-Wheatley Funeral Home		25a. REC'D BY REGISTRAR APR 17 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Frame	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be signed by the attending physician and completely filled out by the funeral director, or it may be signed by the funeral director and completely filled out by the attending physician. Pages 2 and 3 of this certificate should be detached for use as the burial-transit permit. Pages 4 and 5 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wash. D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>2 wks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
3. NAME OF DECEASED (Type or print) <u>CHALMERS</u> First <u>EASTON</u> Middle <u>MILLS</u> Last		4. DATE OF DEATH Month <u>April</u> Day <u>1st</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 22nd, 1905</u>
9. AGE (In years last birthday) <u>56</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sign Painter (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Commercial</u>	
11. BIRTHPLACE (State or foreign country) <u>Alexandria, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Hubert Mills</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Clements Newton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Charles N. Mills, 8321 Old Fort Rd. Wash. 22, DC</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain stem compression</u> 2377 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Brain tumor</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>6 wks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 30</u> , 19 <u>62</u> , to <u>Apr 1</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>March 29</u> , 19 <u>62</u> , and that death occurred at <u>11:55P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>1015 Spring Street, Silver Spring, Md.</u> <u>4/2/1962</u>			
ACTUAL SIGNATURE <u>John T. Lord</u> M.D.		PHYSICIAN'S NAME (Type) <u>John T. Lord</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/5/1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Pr. Geo. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chambers Co. 517--11th St. S.E. Wash. DC</u>		24a. REC'D BY REGISTRAR DATE <u>APR 5 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u>			

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9,60

04782

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04781

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Derwood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(rural)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Redland Rd.</u>		d. STREET ADDRESS <u>Redland Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Vernon George Mobley</u>		4. DATE OF DEATH <u>Apr 23 1962</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-26-1908</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
13. FATHER'S NAME <u>Geo Mobley</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Taylor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		17. INFORMANT <u>Landella Mobley - Sister</u>	
16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>History of previous heart disease</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broscham</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broscham</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/25/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Derwood Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Derwood, Maryland</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>APR 26 '62</u>	
		24b. REGISTRAR'S SIGNATURE <u>C. L. M. M.</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04783

04782

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>6 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, If last known: Residence before admission) <input checked="" type="checkbox"/> a. STATE <u>MD.</u> b. COUNTY <u>11</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>6703 - 40th Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Glady Luellen</u> First Middle Last		4. DATE OF DEATH Month <u>4</u> Day <u>26</u> Year <u>1962</u>	
5. SEX <u>F</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-17-11</u> 9. AGE (in years last birthday) <u>50</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>h.w.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Tennessee</u> 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Graham</u> 14. MOTHER'S MAIDEN NAME <u>Grace Hullett</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute necrotizing bilateral Pneumonia</u> DUE TO (b) <u>Carcinoma of stomach 9 months</u> DUE TO (c) <u>generalized carcinomatosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> <u>1961</u> , to <u>April 26</u> , 19 <u>62</u> , that (I) <u>yes</u> last saw the deceased alive on <u>April 26</u> , 19 <u>62</u> , and that death occurred at <u>11:10</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u> 22c. PHYSICIAN'S NAME (Type)		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS	22b. DATE SIGNED
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/30/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	23d. LOCATION (City, town or county) (State) <u>Colmar Manor Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u> <u>Inc.</u>		25a. REC'D BY REGISTRAR <u>APR 30 '62</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>

TO HOSPITAL OR AFTER DEATH. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04784
04783

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Prince William c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Manassas d. STREET ADDRESS 121 Polk Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Boy "A" MONTGOMERY		4. DATE OF DEATH APRIL 30 19 62	
5. SEX Male 6. COLOR OR RACE Caucasian 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 30 April 1962 9. AGE (In years last birthday) 4 10. IF UNDER 1 YEAR Months 4 Days 14 11. IF UNDER 24 HRS. Hours 4 Min. 14	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Walter C. MONTGOMERY		14. MOTHER'S MAIDEN NAME Alberta Ruth BRILEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 776X DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 30, 1962, to April 30, 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 30, 1962 , and that death occurred at 8:30 PM the causes and on the date stated above.			
22a. SIGNATURE Frederic Schulaner		22b. DATE SIGNED XX May 1, 1962	
22c. PHYSICIAN'S NAME (Type) FREDERIC SCHULANER LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF May 4, 1962	
23c. NAME OF CEMETERY OR CREMATORY Memorial Cemetery		23d. LOCATION (City, town or county) (State) Hot Springs, Ark.	
24. FUNERAL DIRECTOR'S SIGNATURE Baker & Sons Mortuary, Manassas, Va.		25a. REC'D BY REGISTRAR DATE MAY 7 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

2-001231

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be signed by the hospital or attending physician. Part 2 may be signed by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04785
04784

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Koalesville</u> c. LENGTH OF STAY IN TB <u>35 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Koalesville</u> d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA M. J. MORNINGSTAR</u>		4. DATE OF DEATH Month Day Year <u>APRIL 14 1962</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/26/1888</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11c. BIRTHPLACE (County & State, or foreign country) <u>N.Y. State</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick C. Reich</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Richard C. Morningstar</u>	
17. INFORMANT Address <u>Koalesville Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR THROMBOSIS</u> 32a DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALISED ARTERIOSCLEROSIS</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>SEVERE DECUBITUS ULCERS</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>MAY 1961</u> to <u>14 APRIL 1962</u> that (I) (we) last saw the deceased alive on <u>10 APRIL 1962</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.	
22a. SIGNATURE <u>John G. Fawcett</u> M.D.		22b. DATE SIGNED <u>4/14/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN G. FAWCETT</u>		22d. ADDRESS <u>DAWSONVILLE P.O. BOYD, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/17/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>		23d. LOCATION (City, town or county) (State) <u>Beallsville Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Constance C. Hilton</u>		25a. REC'D BY REGISTRAR <u>17 62</u>	
ADDRESS <u>Berensville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04786 CERTIFICATE OF DEATH 04785

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Poolesville c. LENGTH OF STAY IN b. 25 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Poolesville d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ESTHER Middle COMPTON Last MOSSBURG 4. DATE OF DEATH Month April Day 4 Year 1962		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH July 6, 1879 9. AGE (in years last birthday) 82 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Curtis Compher 14. MOTHER'S MAIDEN NAME Henrietta Harper 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No 16. SOCIAL SECURITY NO. Z. M. Compher 17. INFORMANT Poolesville, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO arteriosclerosis Conditions, if any, which gave rise to immediate cause (b) 10 years DUE TO 10 years cause last (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from January 1948 to April 4, 1962 that (I) (we) last saw the deceased alive on April 1, 1962 , and that death occurred at 3:00 P.M. from the causes and on the date stated above.	
22a. SIGNATURE John G. Fawcett 22c. PHYSICIAN'S NAME (Type) John G. Fawcett 22d. ADDRESS Boyd's, Md.		22b. DATE SIGNED 9/4/62 22e. REC'D BY REGISTRAR APR 9 '62 22f. REGISTRAR'S SIGNATURE Arthur S. Harris	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Apr 6-62 23c. NAME OF CEMETERY OR CREMATORY Monocacy Md. 23d. LOCATION (City, town or county) (State) Beallsville Md.		24. FUNERAL DIRECTOR'S SIGNATURE William B. Hutton, Beallsville Md. 25a. REC'D BY REGISTRAR APR 9 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be received by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04787 CERTIFICATE OF DEATH 04786

1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BETHESDA
c. LENGTH OF STAY IN 1b 10 minutes
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SUBURBAN Hospital
2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE MARYLAND b. COUNTY PRINCE GEORGES
c. CITY OR TOWN (if outside corporate limits, write RURAL and give near st town) ADELPHIA
d. STREET ADDRESS 1659-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print) SPENCER THOMAS MULLICAN
4. DATE OF DEATH APRIL 6 19 62
5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ W. DOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 2-4-1899
9. AGE (in years if UNDER 1 YEAR IF UNDER 24 HRS. last birthday) 63 yrs 63 Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 10b. KIND OF BUSINESS OR INDUSTRY Real estate
11. BIRTHPLACE County & State, or foreign country) Rockville, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George W. Mullican 14. MOTHER'S MAIDEN NAME Minnie West
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None 16. SOCIAL SECURITY NO. None 17. INFORMANT Katherine Mullican (Same as above) Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
(a) IMMEDIATE CAUSE (e) Myocardial infarction, anterior wall recent
(b) Obliteration of left descending coronary artery by ruptured atherosclerotic plaque
(c) DUE TO
(d) DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 4, 1962 to April 6, 1962 that (I) (we) last saw the deceased alive on April 4, 1962 and that death occurred April 6, 1962, from the causes and on the date stated above.
22a. SIGNATURE John S. Rogers M.D. 22b. DATE SIGNED April 5, 1962
22c. PHYSICIAN'S NAME (Type) John S. Rogers 22d. ADDRESS 1919 Seminary Rd, Silver Spring, Maryland
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 4-9-62 23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery 23d. LOCATION (City, town or county) (State) Rockville Montgomery Co, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
Warner E. Pumphrey, Inc. Silver Spring, Maryland DATE April 9 '62

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04788
CERTIFICATE OF DEATH
04787

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4425 Bradley Lane</u>		d. STREET ADDRESS <u>4425 Bradley Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Polly Cora Mulville</u>		4. DATE OF DEATH <u>April 15 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 7, 1910</u>
9. AGE (In years last birthday) <u>51 yrs.</u>		IF UNDER 1 YEAR <u>4</u> Months <u>8</u> Days <u>15</u> Hours <u>62</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mississippi</u>	
11. BIRTHPLACE (County & State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jessie T. Milligan</u>		14. MOTHER'S MAIDEN NAME <u>(Unknown) Hallingsworth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-48-6657</u>	
17. INFORMANT <u>Edmund Mulville-Husband-same 2d</u>		Address <u>(Unknown) Hallingsworth</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>METASTATIC MELANOCARCINOMA TO BRAIN, LIVER, LUNG, BONE & SKIN.</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <u>DUE TO MALIGNANT MELANOMA ABDOMINAL WALL</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).		INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u> <u>2 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>MAY 6, 1961</u> to <u>APRIL 15, 1962</u> , that (I) (we) last saw the deceased alive on <u>APRIL 13, 1962</u> , and that death occurred at <u>12:48 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>J. Blaine Fitzgerald</u>		22b. DATE SIGNED <u>4-15-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. Blaine Fitzgerald</u>		22d. ADDRESS <u>8218 Wisconsin Avenue Bethesda</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/18/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>APR 19 1962</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

04788

04789

<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Montgomery</u> <u>MARYLAND</u></p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Germantown</u></p> <p>c. LENGTH OF STAY IN 1b <u>life</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Brownstown</u></p>				<p>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</p> <p>e. STATE <u>Maryland</u> <u>Montgomery</u></p> <p>f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town, <u>Germantown</u></p> <p>g. STREET ADDRESS <u>Brownstown</u></p> <p>h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>3. NAME OF DECEASED (Type or print, First Middle Last)</p> <p><u>MARY A. MUMFORD</u></p>				<p>4. DATE OF DEATH Month Day Year</p> <p><u>April 22, 1962</u></p>			
<p>5. SEX <u>female</u> 6. COLOR OR RACE <u>colored</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH</p> <p><u>Nov. 2, 1909</u></p>				<p>9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.</p> <p><u>52</u> yrs. Months Days Hours Min.</p>			
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u></p>				<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u></p>			
<p>11. BIRTHPLACE (County & State, or foreign country) <u>U.S. A.</u></p>				<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u></p>			
<p>13. FATHER'S NAME <u>William Holly</u></p>				<p>14. MOTHER'S MAIDEN NAME <u>Caroline Unknown</u></p>			
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u></p>				<p>16. SOCIAL SECURITY NO. <u>BOYD, Md.</u></p>			
<p>17. INFORMANT <u>Riley Curtis</u></p>				<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>(a) IMMEDIATE CAUSE (e) <u>Cerebral Thrombosis with rt. hemiplegia</u></p> <p>(b) <u>Arteriosclerotic Cardiovascular Disease</u></p> <p>(c) <u>2 days</u></p> <p>INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u></p>			
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NO</u></p>				<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>			
<p>20c. TIME OF INJURY Month, Day, Year</p> <p><u>19</u></p>				<p>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/></p> <p><u>at work</u> <u>at work</u></p>			
<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>				<p>20f. (City or town) (County) (State)</p>			
<p>21. I certify that (I) (this hospital) attended the deceased from <u>8 March, 1962</u> to <u>22 April, 1962</u>, that (I) <u>NO</u> last saw the deceased alive on <u>22 April, 1962</u>, and that death occurred at <u>5:45 AM</u>, from the causes and on the date stated above.</p>				<p>22a. SIGNATURE <u>Gordon M. Smith, M.D.</u></p> <p>22b. DATE SIGNED <u>23 Apr 62</u></p>			
<p>22c. PHYSICIAN'S NAME (Type, <u>Gordon M. Smith, M.D.</u>)</p>				<p>22d. ADDRESS <u>Barnesville, Md.</u></p>			
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>				<p>23b. DATE THEREOF <u>4/25/62</u></p>			
<p>23c. NAME OF CEMETERY OR CREMATORY <u>Asbury Church.</u></p>				<p>23d. LOCATION (City, town or county) (State) <u>Germantown, Md.</u></p>			
<p>24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u></p>				<p>25a. REC'D BY REGISTRAR <u>APR 30 '62</u></p>			
<p>25b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u></p>				<p>25c. ADDRESS <u>Rockville, Md.</u></p>			

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. It may be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04790

04789

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN b. DOA d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Md. b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gaithersburg d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lurene First Middle Last 4. DATE OF DEATH 4 30 1962 Month Day Year		5. SEX female 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 2/11/1875 9. AGE (In years last birthday) 87 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dressmaker 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Indiana 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Patrick Murphy 14. MOTHER'S MAIDEN NAME Louisa Campbell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. 42202 17. INFORMANT Arteriosclerotic Heart Disease 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis Conditions, if any, which gave rise to immediate cause (b) Severe 1 years (c), stating the underlying cause last. INTERVAL BETWEEN ONSET AND DEATH PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: no		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) August 1961 to April 30, 1962 (County) Rockville (State) Md.		21. I certify that (I) (the hospital) attended the deceased from August 1961 to April 30, 1962 that (I) (we) last saw the deceased alive on April 29, 1962 , and that death occurred at 10:00 A.M. from the causes and on the date stated above.	
22a. SIGNATURE L. Leal 22c. PHYSICIAN'S NAME (Type) L. Leal 22d. ADDRESS Gaithersburg, Md.		22b. DATE SIGNED ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 5-2-62 23c. NAME OF CEMETERY OR CREMATORY Parklawn 23d. LOCATION (City, town or country) Rockville (State) Md.		24. FUNERAL DIRECTOR'S SIGNATURE Robert B. Gartner 25a. REC'D BY REGISTRAR DATE MAY 3 '62 25b. REGISTRAR'S SIGNATURE Charles S. Thomas	

VR A15 (4)
15M 7/61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, and 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04731

04730

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park, c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium & Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) College Park, d. STREET ADDRESS 9704 51st Place,	
3. NAME OF DECEASED (Type or print) Myhre First Middle Last April 25, 19 62 4. DATE OF DEATH Month Day Year April 25, 19 62		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none 10b. KIND OF BUSINESS OR INDUSTRY none 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY America		13. FATHER'S NAME Donald Laverne 14. MOTHER'S MAIDEN NAME Myhre Donna 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no 16. SOCIAL SECURITY NO. no 17. INFORMANT father	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Obstruction 527.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Removal of birth...		INTERVAL BETWEEN ONSET AND DEATH Removal of birth...	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 10th Ave		20f. (City or town) (County) (State) 4/25 1962 to 4/25 1962	
21. I certify that (I) (this hospital) attended the deceased from... 4/25 1962, to... 4/25 1962, that (I) (we) last saw the deceased alive on... 4/25 1962, and that death occurred at 11:30 A.M. from the causes and on the date stated above.		22a. SIGNATURE Raymond F. Chinn 22c. PHYSICIAN'S NAME (Type) Raymond F. Chinn, M. D.	
22b. DATE SIGNED 4/25/62		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 1110 Spring St., Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 4-26-62	
23c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium & Hospital, Takoma Park, Md		23d. LOCATION (City, town or county) (State) Washington Sanitarium & Hospital, Takoma Park, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M. D. Wash. San. & Hosp		25a. REC'D BY REGISTRAR APR 30 '62 25b. REGISTRAR'S SIGNATURE Arthur L. Hare	

2

Bp

04792

CERTIFICATE OF DEATH

Reg. Dist. No. 04791

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE <u>District of Columbia</u> p. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN 1b <u>9 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Chestnut Lodge</u>				d. STREET ADDRESS <u>Dresden Apts, Connecticut Av.</u>			
3. NAME OF DECEASED (Type or print) <u>Charlotte Campbell Nelson</u>				4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 15, 1863</u>	
9. AGE (In years last birthday) <u>99</u> yrs		IF UNDER 1 YEAR Months <u>99</u> Days <u>99</u> Hours <u>99</u> Min <u>99</u>		IF UNDER 24 HRS. Months <u>99</u> Days <u>99</u> Hours <u>99</u> Min <u>99</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Richmond, Virginia</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>DUNCAN G. Campbell</u>				14. MOTHER'S MAIDEN NAME <u>ELEANOR CALVERT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO <u>NONE</u>		17. INFORMANT <u>Kenneth R. Gaarder</u> Address <u>500 W. Montgomery Ave Rockville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>331X</u> DUE TO (b) <u>Senile Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <u>10 years</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-16-62</u> , 19 <u>62</u> , to <u>4-17-62</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>4-16-62</u> , 19 <u>62</u> , and that death occurred at <u>3:07 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Kenneth R. Gaarder</u> M.D.				ADDRESS (Street, city or town, state) <u>500 W. Montgomery Ave</u>			
PHYSICIAN'S NAME (Type) <u>Kenneth R. Gaarder, M.D.</u>				DATE SIGNED <u>Rockville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-18-1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Grolier Sons, Inc. 1756 Pa Ave NW</u>				24a. REC'D BY REGISTRAR <u>Wash DC</u>		24b. REGISTRAR'S SIGNATURE <u>William E. Hanna</u>	
				DATE <u>APR 23 '62</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



04793

CERTIFICATE OF DEATH

Reg. Dist. No. 04792

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN 1b 3 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ALTA VISTA NURSING HOME				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C.			
				d. STREET ADDRESS 6670 32nd STREET, N.W.			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First IDA Middle OESTRICHER Last OESTRICHER				4. DATE OF DEATH Month APRIL Day 3 Year 1962			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 18, 1875	
				9. AGE (In years lost birthday) 86 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) NEW YORK	
13. FATHER'S NAME BERNARD HEIDINGSFELD				14. MOTHER'S MAIDEN NAME THERESA HOMBURGER			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. --- INFORMANT MRS. BERNICE ARONOFF ADDRESS 4500 CONN. AVE., N.W. WASHINGTON, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conjunctive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery Heart disease DUE TO (c) Generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 1 month 10 years 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950 , 19 50 , to 4/2 , 19 62 that I last saw the deceased alive on 3/26 , 19 62 , and that death occurred at 14 M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2500 Calver St. N.W. DATE SIGNED PAUL R. WILNER							
ACTUAL SIGNATURE Paul R. Wilner M.D.							
PHYSICIAN'S NAME (Type) PAUL R. WILNER							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APRIL 5, 1962		22c. NAME OF CEMETERY OR CREMATORY MAIMONIDES CEMETERY		22d. LOCATION (City, town, or county) (State) ELMONT L.I. N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard D. [illegible] ADDRESS 3501-14 ST. NW				24a. RECEIVED BY REGISTRAR DATE APR 6 1962		24b. REGISTRAR'S SIGNATURE Charles S. [illegible]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04734 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04733

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) e. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>High Point - Wash. 14 DC</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>High Point - Wash. 14 DC</u>			
c. LENGTH OF STAY IN 1b <u>6 yrs</u>				d. STREET ADDRESS <u>5831 Osceola ct</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5831 Osceola ct</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Marion Banks Outman</u>				4. DATE OF DEATH <u>Apr 25 1962</u>			
5. SEX <u>Female</u>				6. COLOR OR RACE <u>White</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>Oct 9 1912</u>			
9. AGE (in years last birthday) <u>49</u> yrs.				10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Mins.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>J. N. Banks</u>				14. MOTHER'S MAIDEN NAME <u>Ethel Spencer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Boyd Outman (husband) Item 2</u>				Address <u>—</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u>							
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <u>—</u>							
} DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Apr 29 1962</u>							
Address (Street, city, town, or county) <u>Suitland, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> 22b. DATE THEREOF <u>5-1-1962</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u> 22d. LOCATION (City, town, or country) (State) <u>Suitland, Md.</u>							
23. FUNERAL DIRECTOR <u>Joseph G. Williams, Inc. 1756 Park Ave. NW</u> 24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>—</u>							

MEDICAL CERTIFICATION

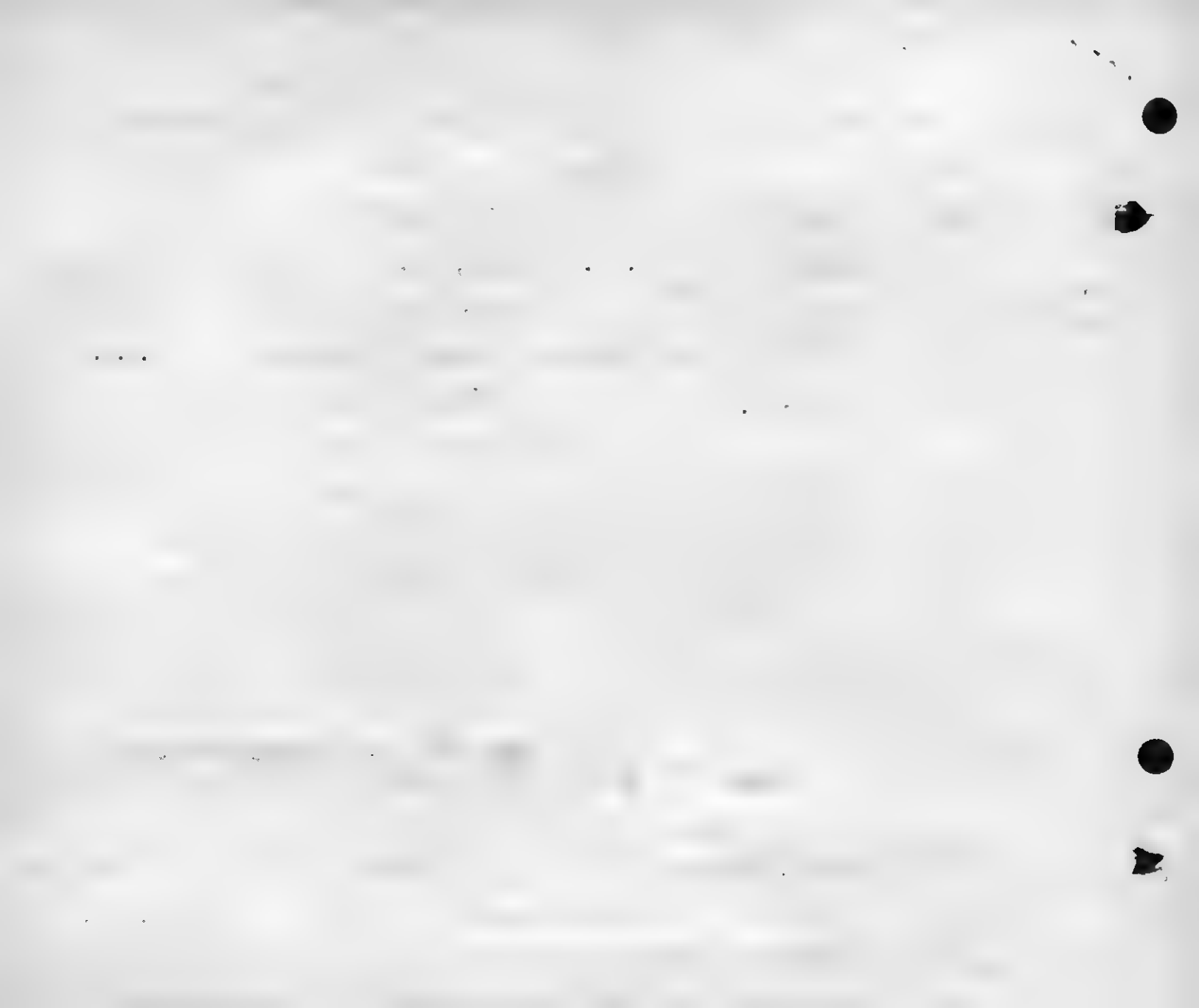
2
B.P.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be filed by the hospital or attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
04795 CERTIFICATE OF DEATH 04794														
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 12 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington d. STREET ADDRESS 3721 Emily Street									
3. NAME OF DECEASED (Type or print) James A. I. Parker, Jr.					4. DATE OF DEATH Month April Day 27 Year 1962									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 3, 1925		9. AGE (In years last birthday) 36 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broker		10b. KIND OF BUSINESS OR INDUSTRY Stock Broker		11. BIRTHPLACE (County & State, or foreign country) Maryland Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.								
13. FATHER'S NAME James A. Parker, Sr.					14. MOTHER'S MAIDEN NAME Mariam Mettee									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No					16. SOCIAL SECURITY NO. 212-20-2052					17. INFORMANT (Doris Parker) wife Address same as above				
18. CAUSE OF DEATH (Enter on only one cause per (a), (b), or (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 152.0 DUE TO (b) splenic infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Resection of lymphosarcoma duodenum PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____										INTERVAL BETWEEN ONSET AND DEATH 1 hr				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that (I) (this hospital) attended the deceased from Apr 17, 1962 to Apr 27, 1962 that (I) (we) last saw the deceased alive on Apr 27, 1962 and that death occurred at 12:35 PM from the causes and on the date stated above.										22a. SIGNATURE John O. Robben				
22c. PHYSICIAN'S NAME (Type) John O. Robben					22d. ADDRESS 1015 SPRING ST. SILVER SPRING MD.		22b. DATE SIGNED April 27, 1962		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 4/30/62		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery			23d. LOCATION (City, town or county) Prince George Co. Md. (State) _____						
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey ADDRESS Bethesda, Maryland					25a. REC'D BY REGISTRAR MAY 4 '62		25b. REGISTRAR'S SIGNATURE Wilbur L. Thomas							



TO HOSPITAL OR AT HOME BY PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be filed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04796
04795

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 812 Bowie Road		e. STREET ADDRESS 812 Bowie Road	
3. NAME OF DECEASED (Type or print) William Kirk Patch		4. DATE OF DEATH April 12 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1921
9. AGE (in years last birthday) 40 yrs.		10. IF UNDER 1 YEAR 10 Months 23 Days 4 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Gov't		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gifford Patch		14. MOTHER'S MAIDEN NAME Frances Kirk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW 2		16. SOCIAL SECURITY NO. 367-03-5843	
17. INFORMANT Margaret Patch, Wife, same 2d		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 237A DUE TO Brucellosis pneumonia + respir. paralysis 48 hrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Hydrocephalus (Internal) Tumor of left ventricle PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Interval between onset and death undetermined "			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of form 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/1/1966 to 4/12/1962 ; that (I) (we) last saw the deceased alive on 4/12/1962 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Stephen N. Jones		22b. DATE SIGNED 4/13/62	
22c. PHYSICIAN'S NAME (Type) Stephen N. Jones		22d. ADDRESS 809 Viers Mill Rd. Rockville, Md.	
23a. BURIAL, CREMATION, or other disposal (Specify) Burial		23b. DATE THEREOF 4/16/62	
23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town or county) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR APR 17 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL DEATH CERTIFICATE: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Newfoundland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Argentia	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS AEWRON 13, Navy 103	
3. NAME OF DECEASED (Type or print) Keith Alan PAVLISIN		4. DATE OF DEATH Month Day Year April 23, 1962	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 1, 1962
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Newfoundland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank (n) Pavlisin		14. MOTHER'S MAIDEN NAME Viola Louise Bower	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. Frank Pavlisin	
17. INFORMANT Same as #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Possible Aspiration pneumonia Conditions, if any, which gave rise to immediate cause (b) 4-4-1 (c) X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 29, 1962 to April 23, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 23, 1962 , and that death occurred 2:45AM from the causes and on the date stated above.			
22a. SIGNATURE F. A. Schulaner		22b. DATE April 23, 1962	
22c. PHYSICIAN'S NAME (Type) F. A. SCHULANER, LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-26-62	
23c. NAME OF CEMETERY OR CREMATORY Haven Hill Bethesda, Md.		23d. LOCATION (City, town or county) (State) Richmond County Ohio, Illinois	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey		25a. REC'D BY REGISTRAR APR 26 '62	
25b. REGISTRAR'S SIGNATURE Chas S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filled in by the attending physician and completed by the hospital or attending physician. Pages 3 and 4 may be filled in by the funeral director. After this certificate has been signed by the attending physician and completed by the hospital or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04798

CERTIFICATE OF DEATH

04797

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in 1b <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Alexandria</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>1000 East Wakefield Drive</u> d. STREET ADDRESS <u>83X 3</u>	
3. NAME OF DECEASED (Type or print) <u>Grier Hartsell Peirce</u>		4. DATE OF DEATH <u>April 12 1962</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 5, 1903</u>	
9. AGE (In years last birthday) <u>58</u>		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>8</u> Hours <u>12</u> Min. <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Natural Gas Engineer</u>		12. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>	
13. FATHER'S NAME <u>Stanley Peirce</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>No</u>		16. SOCIAL SECURITY NO. <u>300-10-5274</u>	
17. INFORMANT <u>The Medical Record</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Myocardial infarction</u> DUE TO (c) <u>Hypertensive Cardiovascular disease with Congestive heart Failure</u>	
19. INTERVAL BETWEEN ONSET AND DEATH <u>5-20 min.</u>		20. YEARS <u>20 min.</u>	
21. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e.g., <u>420</u>)		22. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)	
24a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		24b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
24c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		24d. (City or town) (County) (State)	
25. I certify that I (this hospital) attended the deceased from <u>April 2 4:00</u> to <u>April 12</u> , 1962, that (we) last saw the deceased alive on <u>April 12</u> , 1962, and that death occurred <u>P.M.</u> from the causes and on the date stated above.		26. DATE SIGNED <u>April 13, 1962</u>	
27a. SIGNATURE <u>Edward L. Eyerman</u>		27b. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>	
28a. PHYSICIAN'S NAME (Type) <u>Edward L. Eyerman, M.D.</u>		28b. DATE SIGNED <u>April 13, 1962</u>	
29a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		29b. DATE THEREOF <u>4/14/62</u>	
29c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematorium</u>		29d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>	
30. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Demaine & Son Funeral Home, Alexandria, Va.</u>		31. ADDRESS <u>Wm. Demaine & Son Funeral Home, Alexandria, Va.</u>	
32. REC'D BY REGISTRAR <u>APR 16 '62</u>		33. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit.

VR AIS (4)
15M 7/61

MARYLAND DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN b. 40 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CLARKSVILLE d. STREET ADDRESS 13X-2	
3. NAME OF DECEASED (Type or print) Goulda First Goulda Middle BELL Last PICKETT		4. DATE OF DEATH 4-24-62 Month 4 Day 24 Year 1962	
5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-24-87 9. AGE (In years last birthday) 74 yrs. IF UNDER 1 YEAR: Months 13 Days 2 IF UNDER 24 HRS.: Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER 10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME FRANK KEEFER		14. MOTHER'S MAIDEN NAME LYDIA SHRINER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. HOSPITAL RECORDS	
17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) CHOLENIC NEPHROSIS, XXXX 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) BILIARY CIRRHOSIS DUE TO (c) CARCINOMA PANCREAS, HEAD PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month 4 Day 24 Year 1962 Hour 1:10 P.M.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/15/62 to 4/24/62 , that (I) (we) last saw the deceased alive on 4/24/62 , and that death occurred at 1:10 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Charles S. Whitaker, M.D.		22b. DATE SIGNED 4/25/62	
22c. PHYSICIAN NAME (Type) CHARLES S. WHITAKER, M.D.		22d. ADDRESS CLARKSVILLE, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-27-1962	
23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery		23d. LOCATION (City, town or county) (State) Winfield, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz		25a. REC'D BY REGISTRAR DATE MAY 1 '62	
ADDRESS Box 241, Sykesville, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Knaus	



TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician. Page 2 may be filed by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04801
Items 12 & 14 from 3512 5/2/62 iwk
04300
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONT. Co.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Box 195 Olney Md.</u> c. LENGTH OF STAY IN 1b <u>7 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Brooke Grove Foundation</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONT. Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u> d. STREET ADDRESS <u>1222 Pinecrest Circle</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) <u>John J. Polek</u>	4. DATE OF DEATH <u>April 24 1962</u>	5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-18-1880</u>	9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	IF UNDER 24 HRS. <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>BOCHNIA POLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>															
13. FATHER'S NAME <u>Casimir Polek</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Congenitive heart failure</u> DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>diabetes mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral vascular thrombosis</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5-years</u> <u>2 years</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town, (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>4/18/62</u> 19 <u>62</u> to <u>4/24</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>4/23</u> 19 <u>62</u> , and that death occurred at <u>2:45</u> from the causes and on the date stated above.																			
22a. SIGNATURE <u>John R. Spencer</u>		22b. DATE SIGNED <u>4-24-62</u>		22c. PHYSICIAN'S NAME (Type) <u>John R. Spencer, M. D.</u>		22d. ADDRESS <u>BURTONSVILLE, MARYLAND</u>		22e. REC'D BY REGISTRAR <u>APR 26 '62</u>				22f. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>4-28-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u>		23d. LOCATION (City, town or county) <u>Baltimore Md</u>		23e. (State) <u>Md</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>F W Gzazust Balto. Md</u>												24a. ADDRESS		24b. DATE		24c. REGISTRAR'S SIGNATURE		24d. DATE	

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please secure the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. ATSMC
5M 9/60

MONTGOMERY STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
04802											
04801											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					
c. LENGTH OF STAY IN <u>5 yrs</u>						d. STREET ADDRESS <u>702 Lanack Way</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Margaret Richardson Breinkent</u>						4. DATE OF DEATH <u>Apr 22 1962</u>					
5. SEX <u>Female</u>						6. COLOR OR RACE <u>White</u>					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>3-31-1914</u>					
9. AGE (In years last birthday) <u>48</u> yrs.						10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Store Dept. Store</u>					
11. BIRTHPLACE (State of foreign country) <u>md</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>					
13. FATHER'S NAME <u>John H Snouffer</u>						14. MOTHER'S MAIDEN NAME <u>Julia McKinnless</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>						16. SOCIAL SECURITY NO. <u>577-03-5338</u>					
17. INFORMANT <u>Frederick Breinkent</u>						Address <u>Stim 2</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u>											
420.1 DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis</u>											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
DATE SIGNED <u>Apr 23-62</u>											
ACTUAL SIGNATURE <u>Frank J. Broschelt</u> M.D.											
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHELT</u>											
Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>											
22b. DATE THEREOF <u>4-26-62</u>											
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>											
22d. LOCATION (City, town, or country) (State) <u>Rockville Montgomery Co., Maryland</u>											
23. FUNERAL DIRECTOR <u>Raymond A. Giska</u> Address <u>301 E. North Ave.</u>											
24a. REC'D BY REGISTRAR <u>APR 26 '62</u>											
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>											
25. FUNERAL HOME <u>Warner E. Pumphrey, Inc.</u> <u>Silver Spring, Maryland</u>											

CERTIFICATE OF DEATH

04802

04803

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if not institution; Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
c. LENGTH OF STAY IN 1b 45 days		d. STREET ADDRESS 3119 Rolling Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Allen Ingram PRICE		4. DATE OF DEATH Month Day Year April 11 1962	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1895
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Naval Officer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Anderson Price		14. MOTHER'S MAIDEN NAME Emily Gertrude Bissell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO.	
17. INFORMANT Wife: Mrs. Elizabeth A. Price, Same as #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Confluent Lobular pneumonia DUE TO (b) Carcinoma mouth with metastasis DUE TO (c) Carcinoma mouth with metastasis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, or Part II, of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XX (this hospital) attended the deceased from February 26, 1962 to April 11, 1962 , that XX (we) last saw the deceased alive on April 11, 1962 , and that death occurred at 7:00 PM from the causes and on the date stated above.			
22a. SIGNATURE V.N. Houk		22b. DATE SIGNED 11 April 1962	
22c. PHYSICIAN'S NAME (Type) V.N. HOUK, LCDR MC USN		22d. ADDRESS U.S. Naval Hospital Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-16-61	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Bethesda, Md.		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR APR 16 '62	
25b. REGISTRAR'S SIGNATURE S. H. H.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be filed by the hospital or attending physician.

FOR STATE
HEALTH DEPT.

(M)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 48 hours after death.

04806

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04805

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if installation Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mntg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R.F.D. # 3</u>				d. STREET ADDRESS <u>R.F.D. # 3</u>			
3. NAME OF DECEASED (Type or print) <u>Robert Bundy Ranson</u>				4. DATE OF DEATH <u>Apr. 24 1962</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 29-94</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Col U.S.A. retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DE</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Stacy A. Ranson</u>				14. MOTHER'S MAIDEN NAME <u>M. Levy</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Helene Ranson (wife)</u>				Address <u>Stim 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4-20-1</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHEART</u>				DATE SIGNED <u>Apr 24-1962</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4-27-62</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>				22d. LOCATION (City, town, or country) (State) <u>Arlington Md</u>			
23. FUNERAL DIRECTOR <u>Ernest E. Gaithersburg Md</u>				24a. REC'D BY REGISTRAR <u>APR 30 '62</u>			
				24b. REGISTRAR'S SIGNATURE <u>Clinton S. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be filled in by the attending physician and completed and filed in by the funeral director. After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04807
04806
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in 1b <u>12 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Resmor Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admision) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>3217 19th St N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FELICIA Ann REEVE</u>		4. DATE OF DEATH Month Day Year <u>April 19 1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/13/77</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Tennessee</u>	
13. FATHER'S NAME <u>Felix A. Reeve</u>		14. MOTHER'S MAIDEN NAME <u>Danelson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Rest Home Records</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Nephrosclerosis (Uremia)</u> 475X } DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Generalized Arteriosclerosis</u> (e), stating the underlying cause last. } DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>2 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
19a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		19b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
19c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		19d. (City or town) (County) (State)	
20. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1957</u> to <u>April 19, 1962</u> , that (I) (the) last saw the deceased alive on <u>April 18, 1962</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.			
21. SIGNATURE <u>Thomas S. Sappington</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>THOMAS S. SAPPINGTON</u>		22d. ADDRESS <u>1025 CONNECTICUT AVE. WASH., D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>4/24/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Ft. Myer, Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>St. Hines Co</u>		25a. REC'D BY REGISTRAR <u>2901 145th N.W.</u> DATE <u>APR 23 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>		25c. DATE <u>APR 23 '62</u>	

04808

CERTIFICATE OF DEATH

Reg. Dist. No. 04807

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 44 Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9001 Old Georgetown Road				d. STREET ADDRESS 9001 Old Georgetown Rd.			
3. NAME OF DECEASED (Type or print) Sister Mary Rose Repos.				4. DATE OF DEATH Month April Day 4 Year 19 62			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-8-97	9. AGE (in years last birthday) 64 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Catholic Nun			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Portugal		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Manuel J. Repose				14. MOTHER'S MAIDEN NAME Anna Cardoza			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO no		INFORMANT Address Visitation Convent Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 hour
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Bethesda	(County) Md.	(State)		
21. I certify that I attended the deceased from January , 19 50 to April 4 , 19 62 that I last saw the deceased alive on 4-4 , 19 62 , and that death occurred at 6:45 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Michael J. McInerney				DATE SIGNED 4-4-62			
PHYSICIAN'S NAME (Type) Michael J. McInerney, M.D.				ADDRESS (Street, city or town, state) 1150 Conn Avenue, Washington, D.C.			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-5-62	22c. NAME OF CEMETERY OR CREMATORY Visitation Convent	22d. LOCATION (City, town, or county) Bethesda, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins				24a. REC'D BY REGISTRAR DATE APR 5 '62	24b. REG-STRAR'S SIGNATURE Arthur S. Kiser		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be signed by the attending physician or by the funeral director. After this certificate has been signed by the attending physician and completely filled out, it should be delivered to the funeral director. The funeral director should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04808

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Rockville c. LENGTH OF STAY in lb 3yrs. 11mos d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Waverley Sanitarium				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington c. STREET ADDRESS 532 20th St., N. W. d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BELLE TROTMAN RICHARDSON		4. DATE OF DEATH Month April Day 18 Year 19 62		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 2/4/1870 9. AGE (In years last birthday) 92 yrs. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife 10b. KIND OF BUSINESS OR INDUSTRY -- 11. BIRTHPLACE (County & State, or foreign country) USA 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Calvin Trotman 14. MOTHER'S MAIDEN NAME Mary Elizabeth Harrell		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT Stanley P. Richardson Address Same as #2 above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombus 532X DUE TO Cerebral arterial sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Aug 13, 1962 to Aug 18, 1962 that (I) (we) last saw the deceased alive on Aug 17, 1962 and that death occurred at 9:00 M, from the causes and on the date stated above.							
22a. SIGNATURE Albert E. Marland, Sr. 22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Albert E. Marland, Sr. 22d. ADDRESS 1216 16th St., N.W., Wash., D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 4-20-1962 23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery 23d. LOCATION (City, town or county) Washington, D. C. (State)							
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's Sons 1756 Pa., Ave., N.W. 25a. REC'D BY REGISTRAR DATE APR 23 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Kinner							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The 4 may be recorded by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filled in by the director, page 3 should be detached for use as the burial-transit permit. and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be signed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

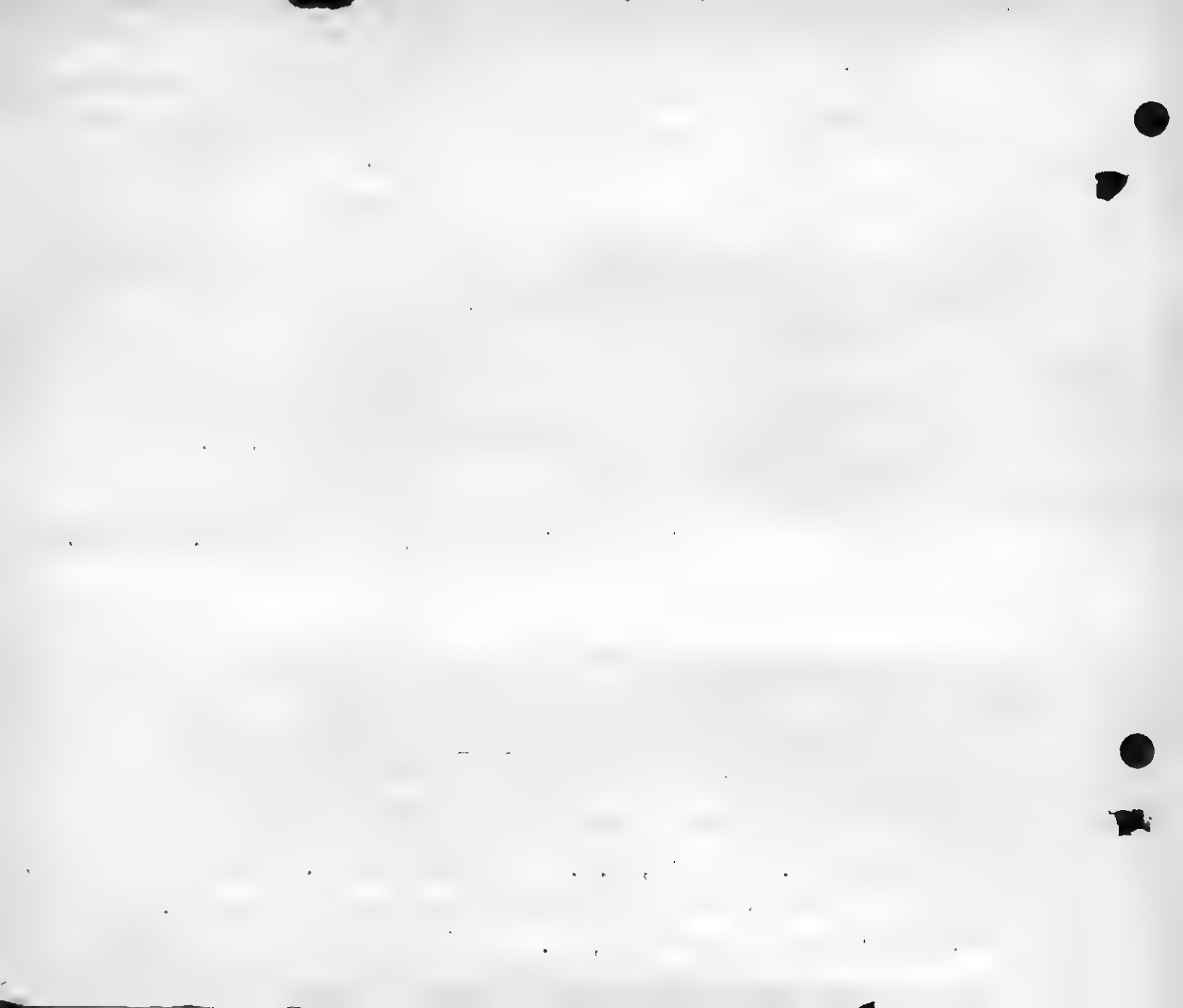
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04810

04809

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton Md c. LENGTH OF STAY in 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 12802 Hathaway Drive		2. USUAL RESIDENCE (Where deceased lived, if institution; and time before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton Md. d. STREET ADDRESS 12802 Hathaway Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle Mae Last Riley		4. DATE OF DEATH Month April Day 22 Year 19 62	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 8, 1879
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 22 Days 19 IF UNDER 24 HRS. Hours 62 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own Home	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George Reeves		14. MOTHER'S MAIDEN NAME Ida Thomas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Idamae Garrett Wheaton, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Insufficiency DUE TO Abnormal Carcinomatosis, Primary Undet. (BIOPSY PROVED) Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, (b) (BIOPSY PROVED) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 week 2 10. . +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from... 2-21-62 ... 19... to... 4-22-62 ... 19... that (I) (we) last saw the deceased alive on... 4-16-62 ... 19... and that death occurred at 11:58 PM , from the causes and on the date stated above.			
22a. SIGNATURE John P. Haberlin M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) John F. Haberlin, M.D.		22d. ADDRESS 1015 Spring St. Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 26, 1962	
23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City, town or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		25a. REC'D BY REGISTRAR APR 25 '62	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas	



CERTIFICATE OF DEATH

04811

04810

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

73

2

1. PLACE OF DEATH a. COUNTY MONTGOMERY				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 4 DAYS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL				d. STREET ADDRESS 13001 LAYHILL ROAD			
3. NAME OF DECEASED (Type or print) ROSALIE		First Middle NMN		Last ROBEY		4. DATE OF DEATH APRIL 27 1962	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-16-29	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME ERNEST W. ROBEY				14. MOTHER'S MAIDEN NAME ALBERTA MCKENZIE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes give war or defense service] NO				16. SOCIAL SECURITY NO. UNKNOWN			
17. INFORMANT HOSPITAL RECORDS				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pyelonephritis 171x DUE TO Conditions, if any, which gave rise to immediate cause (b) Anemia (a), stating the underlying cause last. DUE TO Adenocarcinoma of Cervix (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from APRIL 23 1962 to APRIL 27 1962 that (I) (we) last saw the deceased alive on APR 27 1962 and that death occurred at 11:30P from the causes and on the date stated above.							
22a. SIGNATURE [Signature]				22b. DATE SIGNED 4/28/62			
22c. PHYSICIAN'S NAME (Type) C.H. LIGDON, M.D.				22d. ADDRESS SANDY SPRING, MARYLAND			
23a. BURIAL, CREMATION, OR DISPOSAL (Specify)		23b. DATE THEREOF BURIAL 5/1/62		23c. NAME OF CEMETERY OR CREMATORY W. W. CHAMBERS Co - SILVER SPRING, Md		23d. LOCATION (City, town or county) (State) BARTONSVILLE, Md	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS Co - SILVER SPRING, Md				25a. REC'D BY REGISTRAR MAY 2 '62			
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 may be retained by the hospital or attending physician, and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04812
CERTIFICATE OF DEATH
04811

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville c. LENGTH OF STAY IN 1b years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1004 Crawford Drive		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 1004 Crawford Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY (Mammie) D. Romsburg		4. DATE OF DEATH 4 - 23 - 1962	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-4-1903	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book keeper		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME A. Windsor Davis		14. MOTHER'S MAIDEN NAME Nora Browning	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-14-7020	
17. INFORMANT Mr. Paul L. Romsburg		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO 174X Conditions, if any, which gave rise to immediate cause (b) Blacked ureters (c) Adenocarcinoma of uterus & metastases PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5 yrs	
19. WAS A TUPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 wk 2 wks 5 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/1/1954 to 4/23/1962 that (I) (we) last saw the deceased alive on 4/23/1962 and that death occurred at Rockville, Maryland from the causes and on the date stated above.			
22a. SIGNATURE Dr. Jones		22b. DATE SIGNED 4/23/62	
22c. PHYSICIAN'S NAME (Type) Dr. Jones		22d. ADDRESS M.D. Medical Center Rockville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-28-1962	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Bailey & Son		25a. REC'D BY REGISTRAR MAY 2 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Kenna			

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Small, white, round, smooth, hard, and brittle.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04813
04812

Item 8 Film 0311 4/18/62

1. PLACE OF DEATH
a. COUNTY MONTGOMERY
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BETHESDA
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SUBURBAN HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MARYLAND
b. COUNTY MONTGOMERY
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CHEVY CHASE
d. STREET ADDRESS 8908 MONTGOMERY AVE.

3. NAME OF DECEASED (Type or print)
First Middle Last
MAX F. ROSINSKI

4. DATE OF DEATH
Month Day Year
APRIL 14 19 62

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☐ B. DATE OF BIRTH 10/23/69 68
WIDOWED ☒ DIVORCED ☐

9. AGE (In years last birthday) 93 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED
10b. KIND OF BUSINESS OR INDUSTRY CABINET MAKER
11. BIRTHPLACE (County & State, or foreign country) GERMANY
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Carl Rosinski
14. MOTHER'S MAIDEN NAME Marie Ribnitzki

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
16. SOCIAL SECURITY NO. NONE
17. INFORMANT Address D.C.
Anne R. Fox Daughter 5122 N. Capitol St., N.W.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Infection, small intestine
DUE TO (b) Thrombosis, Superior Mesenteric Artery
DUE TO (c) Atherosclerosis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. None 19
20d. INJURY OCCURRED While ☐ Not While ☐
of work at work
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (th's hospital) attended the deceased from 4:05 PM, 12-5-62 to 4:14 PM, 1962; that (I) (we) last saw the deceased alive on 4-3-62, and that death occurred 7:25 AM, from the causes and on the date stated above.

22a. SIGNATURE John B. Limbourn M.D.
22c. PHYSICIAN'S NAME (Type) JOHN B. Limbourn
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22d. ADDRESS 8875 Conn Ave Wash DC
22b. DATE SIGNED 4/14/62

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE THEREOF APR. 17, 1962
23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S
23d. LOCATION (City, town or county) WASH. D.C. (State)

24. FUNERAL DIRECTOR'S SIGNATURE Geier Funeral Home
ADDRESS 3605 14th St NW Wash DC

25a. REC'D BY REGISTRAR DATE APR 17 '62
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

M

I

MEDICAL CERTIFICATION

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
04814													
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Echo</u>						c. LENGTH OF STAY IN 1b <u>1 evening</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Glen Echo Amusement Park</u>						e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>16 Silver Spring</u>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edward William Rothblum</u>						4. DATE OF DEATH Month Day Year <u>April 19 1962</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-27-44</u>		9. AGE (In years last birthday) <u>17</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Mins.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Montgomery Blair High School</u>				11. BIRTHPLACE (State or foreign country) <u>Pensacola Fla.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Samuel Rothblum</u>						14. MOTHER'S MAIDEN NAME <u>MARY Elizabeth Stone</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>						16. SOCIAL SECURITY NO. <u>213-44-7473</u>		17. INFORMANT <u>BROTHER - Richard Rothblum</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Transsection of cervical spinal cord</u> 912.4 DUE TO <u>Fracture & dislocation C-6 vertebrae</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Multiple injuries</u>												INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.						2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell off + ran over by roller coaster</u>							
20c. TIME OF INJURY Month, Day, Year <u>10:20 p.m. 4-19 1962</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Amusement Park</u>		20f. (City or town) (County) (State) <u>Glen Echo montg md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Frank J. Brotschalt</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) <u>FRANK J. Brotschalt</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>4-20-62</u>							
						Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				22b. DATE THEREOF <u>4-21-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>				22d. LOCATION (City, town, or country) (State) <u>Prince George's Co., Maryland</u>			
23. FUNERAL DIRECTOR <u>Raymond A. Giska</u>						24a. REC'D BY REGISTRAR <u>APR 23 '62</u>						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
Warner E. Pumphrey, Inc. Silver Spring, Maryland													

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04875

04814

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers on pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Res. dance before adm ssn) a. STATE New Jersey	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Bethesda		b. COUNTY ✓	
c. LENGTH OF STAY N 1b 15 days		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Glen Rock	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 150 Fairmont Avenue	
3. NAME OF DECEASED (Type or print) Harvey (No middle name) Rowitz		4. DATE OF DEATH April 10, 1962	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 14 June 1928	
9. AGE (In years last birthday) 33 yrs.		10. IF UNDER 1 YEAR Months 1 Days 35	
11. BIRTHPLACE (Country & State or foreign country) New Jersey		12. IF UNDER 24 HRS. Hours 1 Min. 35	
13. FATHER'S NAME Irving Rowitz		14. MOTHER'S MAIDEN NAME Rose Grobart	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 142-20-7513	
17. INFORMANT The Medical Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 456X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Wegener's Granulomatosis DUE TO (c) 8 1/2 months	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH 1 hr. 35 min	
21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
23. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		24. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		26. (City or town) (County) (State)	
27. I certify that (X) (this hospital) attended the deceased from March 26, 1962 to April 10, 1962 , that (X) (we) last saw the deceased alive on April 10, 1962 , and that death occurred at 11:45 A.M. from the causes and on the date stated above.		28. SIGNATURE Thomas R. Cate M.D.	
29. PHYSICIAN'S NAME (Type) Thomas R. Cate, M.D.		30. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> April 10, 1962	
31. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.		32. DATE APR 12 '62	
33. BURIAL, CREMATION, REMOVAL (Specify) Burial		34. DATE THEREOF April 12, 1962	
35. NAME OF CEMETERY OR CREMATORY Cedar Park Cemetery		36. LOCATION (City, town or county) (State) Emerson, N.J.	
37. FUNERAL DIRECTOR'S SIGNATURE Gooding Funeral Home		38. ADDRESS 4217-9th Ave	
39. REC'D BY REGISTRAR APR 12 '62		40. REGISTRAR'S SIGNATURE Wm. L. Thomas	

1
FOR STATE
HEALTH DEPT.
M
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

04815
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
04815

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg - R-2</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg RFD #2</u>			
c. LENGTH OF STAY IN b. <u>3 yrs</u>				d. STREET ADDRESS <u>Manchester mill Rd</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Glenn Marie Runion</u>				4. DATE OF DEATH <u>Apr 13 1962</u>			
5. SEX <u>Female</u>				6. COLOR OR RACE <u>white</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>2-13-07</u>			
9. AGE (In years last birthday) <u>55</u> yrs.				10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours M. n.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Va</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Bramon Jenkins</u>				14. MOTHER'S MAIDEN NAME <u>Savinia May Jenkins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO <u>None</u>			
17. INFORMANT <u>Raymond Runion (husband)</u>				Address <u>Stn 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>4-13-62</u>			
Address (Street, city, town, or county)				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
22b. DATE THEREOF <u>April 16 1962</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>			
22d. LOCATION (City, town, or country) <u>Rockville Md.</u>				22e. (State)			
23. FUNERAL DIRECTOR <u>Francis H. Barber</u>				ADDRESS <u>Laytonsville, Md.</u>			
24a. REC'D BY REGISTRAR <u>APR 17 '62</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>			

120
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for four files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04816

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN b. <u>DOA 3pm</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hosp.</u>										2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>8401 HARTFORD AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>MAURICE O RYAN</u>					4. DATE OF DEATH Month <u>4</u> Day <u>8</u> Year <u>1962</u>					5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>8-2-1899</u>									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager Am. Hotel Assoc.</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>with</u>					9. AGE (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>									
11. BIRTHPLACE (State or foreign country) <u>Miss</u>										12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>									
13. FATHER'S NAME <u>Leah Ryan</u>										14. MOTHER'S MAIDEN NAME <u>Andrew Britton</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES 1942-19</u>										16. SOCIAL SECURITY NO. <u>501-033097</u> 17. INFORMANT <u>Ellen Ryan (wife)</u> Address <u>Ilum 2</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <u>Coronary occlusion</u> (b) <u>420</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u> </u>															19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.															20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town)					(County)					(State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>4-8-62</u>																			
ACTUAL SIGNATURE <u>Frank J. Birschant</u> EXAMINER'S NAME (Type) <u>FRANK J. BIRSCHANT</u>																			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>4-11-1962</u>					22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cemetery, Arlington, Va.</u>									
22d. LOCATION (City, town, or country)					(State)														
23. FUNERAL DIRECTOR <u>Joseph Gauler</u> ADDRESS <u>1756 Pa Ave</u>																			
24a. REC'D BY REGISTRAR <u>APR 12 '62</u>										24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>									

CERTIFICATE OF DEATH

04817

1. PLACE OF DEATH
a. COUNTY **Montgomery** **MARYLAND**
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) **Bethesda (Rural)** **Newborn**
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **U. S. Naval Hospital**

2. USUAL RESIDENCE (Where deceased lived, if institutions Residence before admission)
a. STATE **Maryland** b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Brentwood**
d. STREET ADDRESS **4508 39th Street**
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) **PAUL** **(N)**
First Middle
4. DATE OF DEATH **April 20, 1962**
Last Month Day Year

5. SEX **Male** 6. COLOR OR RACE **Caucasian** 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH **April 20, 1962**
9. AGE (In years (If UNDER 1 YEAR) IF UNDER 24 HRS. last birthday) Months Days Hours Min. **0 2**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) **Bethesda, Maryland** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **Anthony Joseph Rzasa** 14. MOTHER'S MAIDEN NAME **FLORENCE V. BIEDZYNSKI**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT **(F) ANTHONY J. RZASA** Address **SAME AS # 2 ABOVE**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Anoxia, Neonatorium**
7-1-5 DJE TO (b) **Dystocia, fetal**
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) **Breech, locked chin to symphysis** **2 min**
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (e) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month Day, Year Hour e.m. p.m. **19** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from **20 April, 1962**, to **20 April, 1962**, that ☒ (we) last saw the deceased alive on **20 April, 1962**, and that death occurred **1112 AM** on the causes and on the date stated above.

22a. SIGNATURE **Joel S. Goodwin** M.D. 22b. DATE SIGNED **4-21-62**
22c. PHYSICIAN'S NAME (Type or print) **Joel S. Goodwin, LT MC USN** 22d. ADDRESS **U.S. NAVAL HOSPITAL, BETHESDA, MARYLAND**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE THEREOF **4-25-62** 23c. NAME OF CEMETERY OR CREMATORY **Arlington National** 23d. LOCATION (City, town or county) (State) **Arlington Virginia**

24. FUNERAL DIRECTOR'S SIGNATURE **W.W. Chambers** ADDRESS **517 11th St. Washington, D.C.** 25a. REC'D BY REGISTRAR **APR 24 '62** 25b. REGISTRAR'S SIGNATURE **Arthur S. Kraus**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04819

14. 11692

04818

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN It

2 hrs.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Suburban Hospital

3. NAME OF DECEASED
(Type or print)

PETER ALFRED BOY

5. SEX

MALE

6. COLOR OR RACE

White

7. MARRIED

☐ NEVER MARRIED ☐

☐ WIDOWED ☐

☐ DIVORCED ☐

8. DATE OF BIRTH

April 2 1962

4. DATE OF DEATH

Month

Day

Year

9. AGE (In years last birthday)

10. UNDER 1 YEAR

IF UNDER 24 HRS.

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

JULIAN EDWARD SANTE

14. MOTHER'S M A D E N NAME

MARGARET ELIZABETH SMITH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO

17. INFORMANT

Address

MOTHER SAME AS ABOVE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

760.5 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO

INTRACRANIAL Hemorrhage 2h -
PREMATUREITY

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19

20d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town,

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 4/2 to 4/2, 1962, that (I) (we) last saw the deceased alive on 4/2, 1962, and that death occurred at 10 AM, from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

RICHARD H FISCHER MD

M D

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22d. ADDRESS

4630 MONTGOMERY AVE BETHESDA MD

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

4/4/62

23c. NAME OF CEMETERY OR CREMATORY

St. Mary's Catholic

23d. LOCATION (City, town or county)

Rockville, Montgomery Co., Md.

24. FUNERAL DIRECTOR'S SIGNATURE

Tyson Wheeler Funeral Home

ADDRESS

1391 E. Montgomery Ave. Rockville, Maryland

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE APR 5 '62

Clara J. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS, Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
SM 9/60

04820
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04819

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if not list on Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
c. LENGTH OF STAY IN Ia <u>3 yrs</u>				d. STREET ADDRESS <u>51 Walnut Ave</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>51 Walnut Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Nellie A. SAUVE</u>				4. DATE OF DEATH <u>Apr 28 1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 23 73</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Pa</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>			
13. FATHER'S NAME <u>James Sweeney</u>				14. MOTHER'S MAIDEN NAME <u>Mary Carden</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>Helen Koiss - (Daughter) Item 2</u>			
17. INFORMANT <u>Address</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>subdura</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office b. dg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				DEPUTY MEDICAL EXAMINER <u>2</u>			
22b. DATE THEREOF <u>MAY 1, 1962</u>				DATE SIGNED <u>4-28-62</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>ST. RAYMOND CEMETERY</u>				22d. LOCATION (City, town, or country) (State) <u>Bronx N.Y.</u>			
23. FUNERAL DIRECTOR <u>Arthur Walters</u>				24a. REC'D BY REGISTRAR <u>APR 30 '62</u>			
ADDRESS <u>254 CARROLL ST NW</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneale</u>			

16
FOR STATE
HEALTH DEPT. (M)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04820

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville
c. LENGTH OF STAY IN 1b 12 yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 13102 Okinawa Rd

2. USUAL RESIDENCE (Where deceased lived, if not last on: Residence before admission)
a. STATE md b. COUNTY montg
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville
d. STREET ADDRESS 13102 Okinawa Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Reinhold Ferdinand Schilling
4. DATE OF DEATH Apr 13 1962
5. SEX male 6. COLOR OR RACE white 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 12-18-95
9. AGE (In years last birthday) 66 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inst. maker Bureau of Standards
10b. KIND OF BUSINESS OR INDUSTRY Germany
11. BIRTHPLACE (State or foreign country) U.S.A.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME August Schilling 14. MOTHER'S MAIDEN NAME Kurt
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. Augusta Schilling (wife) 17. INFORMANT Sten
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4-2-61 DUE TO Coronary occlusion
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO hypertension
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐ M.D. Frank J. Broesch DATE SIGNED 4-13-62
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type) FRANK J. BROESCH Address (Street, city, town, or county) Prince George Co., Maryland
22a. BURIAL, CREMATION, or REMOVAL (Specify) burial 22b. DATE THEREOF 4/17/62 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill 22d. LOCATION (City, town, or country) (State) Prince George Co., Maryland
23. FUNERAL DIRECTOR Lyson ADDRESS 13102 Okinawa Rd, Rockville, Md. 24a. REC'D BY REGISTRAR APR 16 '62 24b. REGISTRAR'S SIGNATURE Arthur S. Frazier

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be filed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04822 CERTIFICATE OF DEATH 04821

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4512 Saul Road</u>		d. STREET ADDRESS <u>4512 Saul Road</u>	
3. NAME OF DECEASED (Type or print) <u>Mary Agnes Schofield</u>		4. DATE OF DEATH <u>April 23 1962</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 27, 1894</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Fallon</u>		14. MOTHER'S MAIDEN NAME <u>Ella Kennan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Henry N. Schofield-Husband-Same 2d</u>		Address <u>-----</u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiovascular collapse</u> DUE TO (b) <u>acute myocardial infarction</u> DUE TO (c) <u>generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cerebral vascular accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>-----</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>		20f. (City or town) <u>-----</u> (County) <u>-----</u> (State) <u>-----</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 1956</u> to <u>April 1962</u> that (I) (we) last saw the deceased alive on <u>April 23 1962</u> and that death occurred at <u>1:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Wilfred R. Ehrmantraut</u>		22b. DATE SIGNED <u>4/24/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wilfred R. Ehrmantraut</u>		22d. ADDRESS <u>4890 Battery Lane, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/26/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		23d. LOCATION (City, town or county) <u>Silver Spring, Maryland</u> (State) <u>-----</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>APR 26 1962</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur A. HATTON</u>	

1
FOR STATE
HEALTH DEPT. M
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
04823											
04822											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mntg</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>						
c. LENGTH OF STAY IN 1b <u>DOA</u>					d. STREET ADDRESS <u>3910 Elby St</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hosp</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>Leater Samuel Scott</u>					4. DATE OF DEATH <u>Apr 22 1962</u>						
5. SEX <u>male</u>					6. COLOR OR RACE <u>white</u>						
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>Sept 24-94</u>						
9. AGE (If years last birthday) <u>67</u> yrs.					10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>22</u> Hours <u>22</u> Min. <u>67</u>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Business Executive - Plummer Co.</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>min.</u>						
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						
13. FATHER'S NAME <u>Walter Scott</u>					14. MOTHER'S MAIDEN NAME <u>Anna Hawley</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>					16. SOCIAL SECURITY NO. <u>578-09-3288</u>						
17. INFORMANT <u>Eliz. Scott - Sister</u>					Address <u>Stun 2</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A cute myocardial infarction</u> 4-2-62 } DUE TO <u>Hemorrhage into arteriosclerotic plaque of coronary artery</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>Arteriosclerosis, coronary</u>										INTERVAL BETWEEN ONSET AND DEATH <u>Four hours</u> <u>Four hours</u> <u>months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Fell in bath room at home</u>	
20c. TIME OF INJURY Month, Day, Year <u>4-22-1962</u> Hour <u>2:40</u> P.M.										20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>										20f. (City or town) <u>Wheaton</u> (County) <u>mntg</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Frank J. Brosehan</u> M.D.										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSEHAN</u>										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <u>4-23-62</u>										DATE SIGNED <u>4-23-62</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>										22b. DATE THEREOF <u>4/25/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem. Ft. Myer, Va.</u>										22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR <u>The S.H. Hines Co. 2901 14th St. N.W. Washington 9, D.C.</u>										24a. REC'D BY REGISTRAR <u>APR 24 1962</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hays</u>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician. Page 2 may be filed by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04824

04823

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN

7 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Suburban

2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)

a. STATE

b. COUNTY

New York

Rensselaer

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hoosick Falls

d. STREET ADDRESS

140 Main Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED
(Type or print)

Sylvester E. Scott

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

Aug. 8, 1888

9. AGE (In years last birthday)

73 yrs.

IF UNDER 1 YEAR

Months

8

Days

7

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Lawyer

10b. KIND OF BUSINESS OR INDUSTRY

Self-employed

11. BIRTHPLACE (County & State, or foreign country)

New York

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Edmund Scott

14. MOTHER'S MAIDEN NAME

Mary Newman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

no

16. SOCIAL SECURITY NO.

Unknown

17. INFORMANT

Mrs. Richard Bryant/11831 Falls Rd. - Rockville, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

Intracerebral hemorrhage, massive
Arteriosclerosis, cerebral

3 3 X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I. of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from April 7, 1962 to April 15, 1962 that (I) (we) last saw the deceased alive on April 14, 1962 and that death occurred April 15, 1962 from the causes and on the date stated above.

22a. SIGNATURE

G. Bowditch Hunter, Jr. M.D.

ATTENDING PHYS. ☒

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

April 15, 1962

22c. PHYSICIAN'S NAME (Type)

G. BOWDITCH HUNTER, JR.

22d. ADDRESS

809 Viers Mill Rd, Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

Burial-transit 4-16-62

23c. NAME OF CEMETERY OR CREMATORY

St. Mary's Cemetery

23d. LOCATION (City, town or county)

Hoosick Falls, New York

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Bethesda, Md.

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE FEB 19 '62



TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM
5M 9/60

1
FOR STATE
HEALTH DEPT.

M

1

MEDICAL CERTIFICATION

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
04824											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institutions Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mnty</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg (rural)</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg (rural)</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pond on Transon Farm</u>						d. STREET ADDRESS <u>RFD #1</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>David Lee Sell</u>						4. DATE OF DEATH Month Day Year <u>Apr 26 1962</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-12-56</u>		9. AGE (in years last birthday) <u>5</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harlan W. Sell</u>						14. MOTHER'S MAIDEN NAME <u>Catherine S. Shipe</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Harlan W. Sell Rt. #1 Gaithersburg, Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>CHOKING</u> DUE TO <u>choking</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was boating on pond and drowned</u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>10:30 p.m. 4-26-1962</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>pond</u>		20f. (City or town) <u>Gaithersburg R-1 mnty md</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Brosch</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>4-29-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Goshen</u>		22d. LOCATION (City, town, or country) (State) <u>Goshen, Mont. Maryland</u>	
23. FUNERAL DIRECTOR <u>Francis H. Barber</u>						24a. REC'D BY REGISTRAR DATE <u>APR 30 '62</u>					
24b. REGISTRAR'S SIGNATURE <u>Curtis L. Hume</u>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be completed by the hospital or attending physician. Page 2 may be completed by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

1
04825
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
04825

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN IB d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>FAIRLAND NURSING HOME</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> d. STREET ADDRESS <u>700 BAYFIELD ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>SARAH</u> First <u>SHAPIRO</u> Middle <u>SHAPIRO</u> Last 4. DATE OF DEATH Month <u>4</u> Day <u>14</u> Year <u>1962</u>		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>JUNE 3, 1888</u> 9. AGE (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>ABRAHAM KLEBANOFF</u> 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>DEBBIE A SHAPIRO</u> Address <u>SON</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic Carcinoma</u> DUE TO (b) <u>Carcinoma of Breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). INTERVAL BETWEEN ONSET OF DEATH <u>3 months</u> <u>18 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>1944</u> , 19 <u>44</u> , to <u>4/14</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>4/14</u> , 19 <u>62</u> , and that death occurred at <u>11 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Irving W. Winik</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Irving W. Winik</u> 22d. ADDRESS <u>3900 McKinley St. N.W.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>4/15/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>4/16/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>NAT'L CAP HEB. Cem.</u> 23d. LOCATION (City, town or county) (State) <u>WASH. DC.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u> ADDRESS <u>4217 9th St. N.W.</u> 25a. REC'D BY REGISTRAR DATE <u>APR 19 1962</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kramer</u>	

CERTIFICATE OF DEATH

Reg. Dist. No. 04826

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING 34	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BEL PRE NURSING HOME		d. STREET ADDRESS 12717 HODDRIDGE ROAD	
3. NAME OF DECEASED (Type or print) First Middle Last SUSIE SHEAR		4. DATE OF DEATH Month Day Year APRIL 24, 1962 19	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 15, 1904
9. AGE (in years last birthday) 57 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MORRIS ROSENBERG		14. MOTHER'S MAIDEN NAME REBECCA ---	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO UNKNOWN	
17. INFORMANT IRVING SHEAR ROCKVILLE, MARYLAND		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cerebral arteriosclerosis 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) gen'lized DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 wks 4 yrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 2/1, 1962 , to 4/24/1962 , that I last saw the deceased alive on 4/14/1962 , and that death occurred at 11:25 AM , from the causes and on the date stated above.	
21. ACTUAL SIGNATURE Donald Nelson		21. ADDRESS (Street, city or town, state) DATE SIGNED 10620 Georgia Ave, Silver Spring, MD. 4/24/62	
21. PHYSICIAN'S NAME (Type) DONALD NELSON, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
22b. DATE THEREOF 4-27-62		22c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN FALLS CHURCH, VA.	
22d. LOCATION (City, town, or county) (State) VA.		23. FUNERAL DIRECTOR'S SIGNATURE BERNARD DANZANSKY & SONS	
23. ADDRESS 3501 14th St. N		24a. REC'D BY REGISTRAR APR 30 '62	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 4. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN TB <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash Stn & Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>624 Edmonston Dr</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Virginia Shelkett</u> First Middle Last		4. DATE OF DEATH <u>4-12-62</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-22-80</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Ryan</u>		14. MOTHER'S MAIDEN NAME <u>Louise Saunders</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. E. J. Ballou</u> Address <u>Stineabove</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis with myocardial infarction</u> DUE TO (b) <u>Generalized arterio-sclerosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Several years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 1960</u> to <u>April 12, 1962</u> that (I) (we) last saw the deceased alive on <u>April 12, 1962</u> and that death occurred at <u>5:45 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Bennet A. Porter, Jr.</u>		22b. DATE SIGNED <u>April 12, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr., M.D.</u>		22d. ADDRESS <u>9301 Colesville Rd, Silver Spring, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-15-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Hill Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Starford</u> <u>Starford Co., Virginia</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>		25. REGISTRAR'S SIGNATURE <u>Raymond A. Ziska</u>	
25a. REC'D BY REGISTRAR <u>APR 16 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Raymond A. Ziska</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

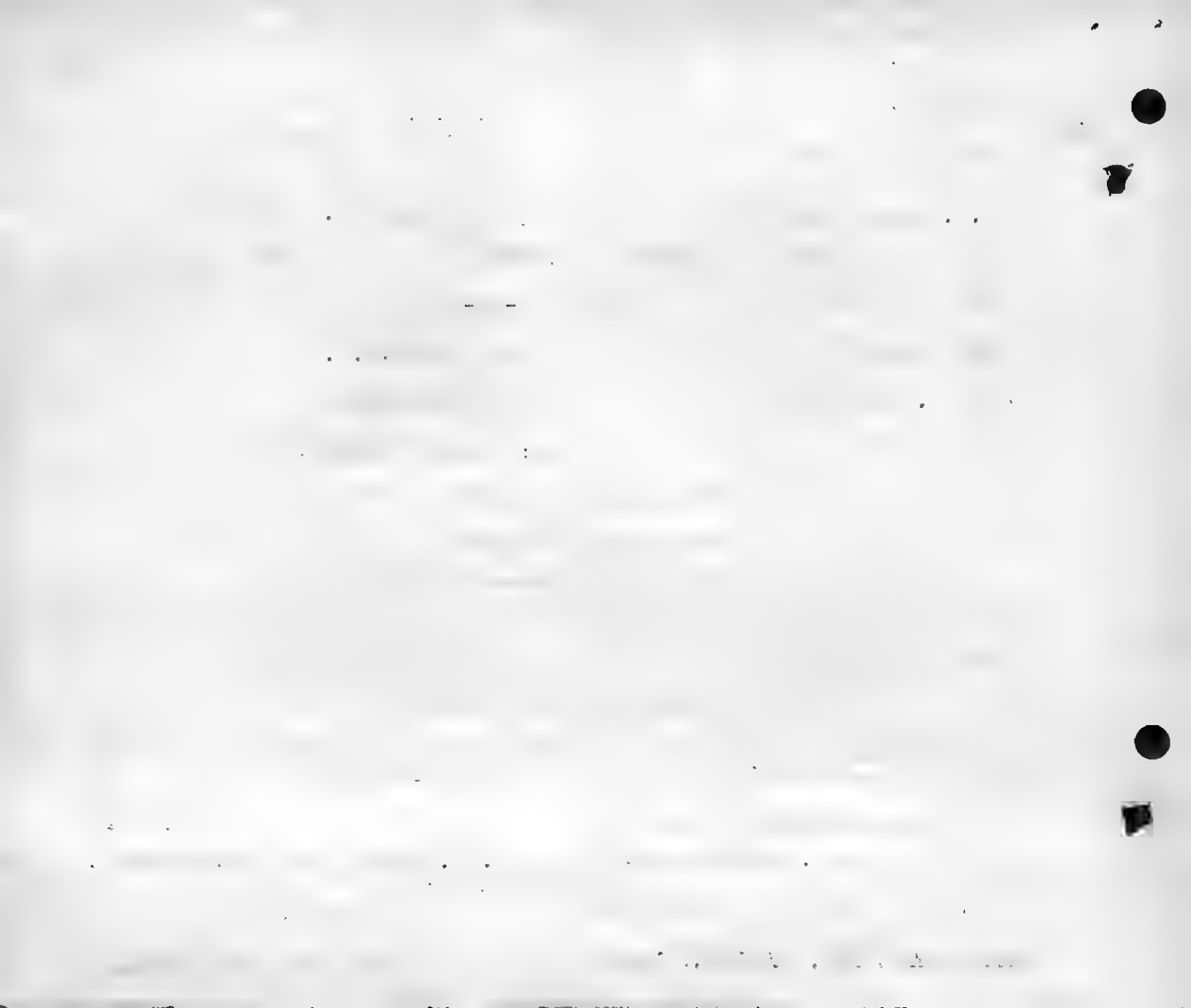
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04829

04828

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (rural)</u> c. LENGTH OF STAY IN 1b <u>17 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U.S. Naval Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Herndon</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Herndon</u> d. STREET ADDRESS <u>506 Elden St. Route #1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Robert</u> Last <u>SHEMELD</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>7</u> Year <u>19 62</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-26-08</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Marine Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John L. SHEMELD</u>		14. MOTHER'S MAIDEN NAME <u>Louise JACOBS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WIFE: KATHERINE SHEMELD, Same as # 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE <u>Bacilar artery thrombosis.</u> DUE TO <u>Arteriosclerosis</u> DUE TO <u>diabetes mellitus.</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> e.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 22</u> , 19 <u>62</u> to <u>April 7</u> , 19 <u>62</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>April 7</u> , 19 <u>72</u> , and that death occurred at <u>1140 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>John R. Warmolts MD.</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>JOHN R. WARMOLTS LT MC USN</u>		22b. DATE SIGNED <u>April 7, 1962</u> 22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-10-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON</u>	23d. LOCATION (City, town or county) (State) <u>ARLINGTON, VIRGINIA</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Green</u> GREEN FUNERAL HOME, HERNDON, VIRGINIA		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>APR 12 '62</u> <u>Arthur S. House</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

MEDICAL CERTIFICATION

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
04831											
1. PLACE OF DEATH a. COUNTY <u>Montgomery.</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>D.O. 4</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH STN + Hosp</u>						2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RF Silver Spring</u> d. STREET ADDRESS <u>R.F.D. 2 -</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Ruth</u> First <u>Ann</u> Middle <u>Slaughter</u> Last			4. DATE OF DEATH Month <u>4</u> Day <u>17</u> Year <u>1962</u>			5. SEX <u>F</u>			6. COLOR OR RACE <u>C</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>3-12-92</u>			9. AGE (In years last birthday) <u>70</u> yrs.			10. IF UNDER 1 YEAR Months Days		
11. BIRTHPLACE (State or foreign country) <u>Wash D.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			13. FATHER'S NAME <u>William Stewart</u>			14. MOTHER'S MAIDEN NAME <u>Isabelle Baker</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u> </u>			17. INFORMANT <u>Mr. Stephen H. Slaughter</u> Address <u>Husband</u>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thoracic hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Crushed chest</u> <u>Auto accident</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>Wagon fire in car which was struck by other car</u>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year <u>4-17 1962</u> Hour <u>4:35</u> p.m.						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>						20f. (City or town) <u>Silver Spring</u> (County) <u>Montgomery</u> (State) <u>Md.</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>4/21/62</u>					
22c. NAME OF CEMETERY OR CREMATORY <u>Good Hope.</u>						22d. LOCATION (City, town, or country) (State) <u>Colesville, Md.</u>					
23. FUNERAL DIRECTOR <u>Robert R. Szwed</u> ADDRESS <u>Rockville, Md.</u>						24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u> </u>					
DATE <u>APR 25 '62</u>						DATE SIGNED <u>4-18-62</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be relayed by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04832

CERTIFICATE OF DEATH

04831

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>Washington, D. C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GERMANTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u>	
c. LENGTH OF STAY IN 1b <u>2 Mos - 13 days</u>		d. STREET ADDRESS <u>3813 Warren St., N. W.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>THE MARYLANDER HOME OF REST INC</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JENNY</u> Middle <u>M</u> Last <u>SMALL</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>18</u> Year <u>1962</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 8, 1882</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>18</u> Hours <u>18</u> Min <u>18</u>	IF UNDER 74 HRS. Months <u>7</u> Days <u>18</u> Hours <u>18</u> Min <u>18</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Public Schools</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NEW HAVEN, CONN</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John Copperthite</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Wood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mrs. Wm. J. O'Neil - 4022 Veazey St., N. W., D.C.</u>	
17. INFORMANT <u>Mrs. Wm. J. O'Neil</u>		Address <u>- 4022 Veazey St., N. W., D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO <u>Intermittent cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intermittent cardiovascular disease</u> DUE TO <u>Intermittent cardiovascular disease</u> (c) <u>Intermittent cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/15</u> 19 <u>62</u> to <u>4/18</u> 19 <u>62</u> that I last saw the deceased alive on <u>4/16</u> 19 <u>62</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Washington, D. C.</u>	
ACTUAL SIGNATURE <u>James S. Birch</u> M.D. <u>James S. Birch</u>		DATE SIGNED <u>4/18/62</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/21/62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Rood</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph F. Birch's Sons</u> ADDRESS <u>3034 M St. N. W., D. C.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 23 '62</u>	
		24b. REGISTRAR'S SIGNATURE <u>James S. Birch</u>	

A. L. Haycock

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be returned by the hospital or attending physician. Page 2 may be returned by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04833

04832

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Iakoma Park</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San + Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONT.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>850 A. NORTHAMPTON DR.</u>	
3. NAME OF DECEASED (Type or print) <u>Harry P. Smithers</u>		4. DATE OF DEATH Month <u>4</u> Day <u>8</u> Year <u>1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-21-1892</u>
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A. Jenkins</u>	
13. FATHER'S NAME <u>Thomas Jefferson Smithers</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Huxter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>127-09-3167</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerotic Heart Disease - Myocardial Ischemia</u> (c) <u>Ischemia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> <u>2 years</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 1, 1961</u> to <u>Apr. 8, 1962</u> that (I) (we) last saw the deceased alive on <u>Apr. 6, 1962</u> and that death occurred about <u>6:00 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>James L. Laubach</u>		22b. DATE SIGNED <u>4/8/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES L. LAUBACH</u>		22d. ADDRESS <u>1806 FOX Rd - Hyattsville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>APR. 10, 1962</u>	
23c. NAME OF CEMETERY OR CREMATOR <u>OAK WOOD</u>		23d. LOCATION (City, town or county) (State) <u>RICHMOND Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Tattum</u>		25a. REC'D BY REGISTRAR <u>APR 11 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Unahus S. Hume</u>	

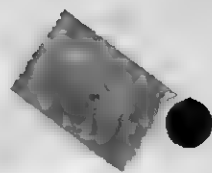


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 of this certificate is to be signed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01834
04833
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 3 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Pennsylvania b. COUNTY Nanty-Glo c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route #1, Box 133A d. STREET ADDRESS April 12 19 62	
3. NAME OF DECEASED (Type or print) Donald Richard Snedden		4. DATE OF DEATH April 12 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1927
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Body Repairman		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania	
13. FATHER'S NAME William Snedden		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes 1945 - 1947		17. INFORMANT The Medical Record	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Collapse DUE TO Staphylococcal Septicemia Conditions, any, which gave rise to immediate cause (a), stating the underlying cause last. Acute Renal Failure Urate Nephropathy DUE TO Acute Lymphatic Leukemia		INTERVAL BETWEEN ONSET AND DEATH 18 Hours 16 Hours 16 Hours 3 Weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that X (this hospital) attended the deceased from April 9, 19 62 to April 12, 19 62 that 10 (we) last saw the deceased alive on April 12 19 62 , and that death occurred at 8:05 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Robert H. Levin		22b. DATE SIGNED 4/13/62	
22c. PHYSICIAN'S NAME (Type) ROBERT H. LEVIN, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 4-13-62		23b. DATE THEREOF 4-13-62	
23c. NAME OF CEMETERY OR CREMATORY E. U. B. Cemetery		23d. LOCATION (City, town or county) (State) Cambria County, Penna.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25. REC'D BY REGISTRAR APR 19 62	
ADDRESS Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Haines	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04835
04834
CERTIFICATE OF DEATH

Item 9 Film 0311-4/16/62 mh

1. PLACE OF DEATH
a. COUNTY **Montgomery** MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Silver Spring**
c. LENGTH OF STAY IN 1b **2 mo.**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **LeDeau Gardens Barker St.**

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE **D. C.**
b. COUNTY **Washington**
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **3416 - B St. S.E.**
d. STREET ADDRESS **Washington**

3. NAME OF DECEASED (Type or print)
First Last Middle Initial
Viola Caroline SPENCER

4. DATE OF DEATH
Month Day Year
APRIL 3 1962

5. SEX **F**
6. COLOR OR RACE **CAUCASIAN**
7. MARRIED ☐ NEVER MARRIED ☐ B. DATE OF BIRTH **Nov. 16 1884**
8. ☒ WIDOWED ☐ DIVORCED ☐ 9. AGE In years last birthday IF UNDER 1 YEAR Months Days Hours Min. **77 7 7**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housewife**
10b. KIND OF BUSINESS OR INDUSTRY **New Brunswick Canada**
11. BIRTHPLACE (County & State, or foreign country) **U.S.A.**
12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Benjamin Applebee**
14. MOTHER'S MAIDEN NAME **Frances Seeley**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) **No**
16. SOCIAL SECURITY NO. **Mrs. Anne Spencer**
17. INFORMANT **Poolesville, Md. Rt. 1**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) **UREMIA**
4 4 2X DUE TO **PYELO NEPHRITIS, CHRONIC**
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO **NEPHROSCLEROSIS**
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) **HYPERTENSIVE CARDIOVASCULAR DISEASE**

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐
20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. **19**
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. City or town (County) (State)

21. I certify that (I) (this hospital) attended the deceased from **MAR. 28, 1962** to **APR. 3, 1962** that (I) (we) last saw the deceased alive on **APR. 3, 1962**, and that death occurred at **9:28**, from the causes and on the date stated above.

22a. SIGNATURE **Robert T. Thibadeau** M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED **APR. 3-62**
22c. PHYSICIAN'S NAME (Type) **ROBERT T. THIBADEAU** 22d. ADDRESS **10609 CONCORD ST. KENSINGTON MD**

23a. BURIAL, CREMATION, 23b. DATE THEREOF **Burial 4/6/62**
23c. NAME OF CEMETERY OR CREMATORY **Monocacy**
23d. LOCATION (City, town or county) (State) **Beallsville Md.**

24. FUNERAL DIRECTOR'S SIGNATURE **Constance C. Hilton** ADDRESS **Barnesville, Md.**
25a. REC'D BY REGISTRAR **APR 9 '62** 25b. REGISTRAR'S SIGNATURE **Arthur S. Kline**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04835

04835

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>23 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>		2. USUAL RESIDENCE (Where deceased lived, if inst. luit on: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Point Pleasant</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Route #1, Box 113</u> d. STREET ADDRESS <u>Route #1, Box 113</u>	
3. NAME OF DECEASED (Type or print) <u>Leslie Charles Sperow</u> First Middle Last e. SEX <u>Male</u> f. COLOR OR RACE <u>White</u> g. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> h. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u> i. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u> j. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1962</u> k. AGE (In years last birthday) <u>8</u> yrs. IF UNDER 1 YEAR: Months <u>8</u> Days <u>19</u> Hours <u>62</u> Min. IF UNDER 24 HRS. l. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u> m. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> n. FATHER'S NAME <u>Charles B. Sperow, Jr.</u> o. MOTHER'S MAIDEN NAME <u>Sylvia Y. Gehri</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>The Medical Records</u> <u>The Clinical Center, Bethesda 14, Maryland</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Thrombocytopenia</u> (c) <u>Acute Lymphocytic Leukemia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>1 month</u> <u>18 months</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II. of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 30, 1962</u> to <u>April 22, 1962</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>April 22, 1962</u> and that death occurred at <u>8:15AM</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>Robert H. Levin</u> 22c. PHYSICIAN'S NAME (Type) <u>Robert H. Levin, M.D.</u>		22b. DATE SIGNED <u>April 3, 1962</u> 22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>3/25/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Elmwood Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Shepherdstown, W. Va.</u>		25a. REC'D BY REGISTRAR <u>APR 26 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thane</u>	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

01837
04836
MONTGOMERY COUNTY
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hosp.		d. STREET ADDRESS R F D -	
3. NAME OF DECEASED (Type or print) Russell Albert Stewart		4. DATE OF DEATH Month Day Year 4 23 1962	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-31-35
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. PLACE OF BIRTH (State or foreign country) Maryland	
13. FATHER'S NAME MR Percy Stewart		14. MOTHER'S MAIDEN NAME Mary Savoy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, not or unknown) (If yes give war and dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC AND RESPIRATORY FAILURE DUE TO (b) ELECTROCUTION Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Referred lemming against crane which contacted high tension wires	
20c. TIME OF INJURY Hour 3:00 p.m. Month, Day, Year 4-23 1962		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> el work el work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Adelphia P.G. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-27-62	
22c. NAME OF CEMETERY OR CREMATORY St. Simons Church Croom		22d. LOCATION (City, town, or country) (State) md	
23. FUNERAL DIRECTOR Rollins, Myrtle K.		24a. REC'D BY REG. STRAR APR 30 1962	
24b. REGISTRAR'S SIGNATURE Arthur L. Thrane			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be pronounced by the attending physician and completely filled out by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04838

CERTIFICATE OF DEATH

04837

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. LENGTH OF STAY IN 1b 10 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10008 CRESTWOOD ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First MARGARET Middle BORYER Last STONER		4 DATE OF DEATH Month APRIL Day 6 Year 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 31 1925
9 AGE (in years last birthday) 37 yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BACTERIOLOGIST		10b. KIND OF BUSINESS OR INDUSTRY US GOVT	
11. BIRTHPLACE (State or foreign country) WASHINGTON MARYLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS C GEAFY		14. MOTHER'S MAIDEN NAME ANNA BORYER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16 SOCIAL SECURITY NO. NONE	
17. INFORMANT DANIEL DOUB STONER KENSINGTON MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARRHYTHMIA (SUPRAVENTRICULAR TACHYCARDIA) DUE TO ACUTE GASTRITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) ACUTE GASTRITIS DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 12 HRS. 2 DAYS			
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PARAPLEGIA DUE TO BULBOSPINAL POLIOMYELITIS			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/6/62 , 19, to 4-7-62 , 19, that I last saw the deceased alive on 4/6/62 , 19, and that death occurred at 11:25 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7720 WISCONSIN AVE DATE SIGNED 4/8/62 ACTUAL SIGNATURE Henry C. Scruggs M.D. PHYSICIAN'S NAME (Type) HENRY C SCRUGGS M. D. BETHESDA MARYLAND			
22a BURIAL, CREMATION, REMOVAL, (Specify) BURIAL		22b DATE THEREOF 4-10-62	
22c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Super-Rouzer Funeral Home		24a REC'D BY REGISTRAR DATE APR 10 '62	
24b. REGISTRAR'S SIGNATURE Charles S. Hanna			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

13
04839
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04838
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring,</u>	
c. LENGTH OF STAY IN 1b <u>18 days</u>		d. STREET ADDRESS <u>3703 Elby St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bessie</u> First Middle Last		4. DATE OF DEATH <u>April 25</u> 19 <u>62</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/10/81</u>
9. AGE (in years last birthday) <u>80</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
11. BIRTHPLACE <u>Conn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Schyman</u>		14. MOTHER'S MAIDEN NAME <u>Jenny</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Lorraine Smith, daughter same</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Shock - poss. coronary + cerebral infarct</u> (b) <u>diabetes - generalized arteriosclerosis</u> (c) <u>None</u> Condition gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>intra-abdominal mass</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 7, 1962</u> to <u>7-25</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>April 25</u> , 19 <u>62</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>John J. Merendino</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>John J. Merendino</u>		22d. ADDRESS <u>11601 Newport Mill Rd. S.S., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Apr 30, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arl. Nat'l. Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Arl., Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Hume</u>		25a. REC'D BY REGISTRAR <u>APR 30 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>		25c. ADDRESS <u>4217 9th St., N.W.</u>	

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04840

CERTIFICATE OF DEATH

04839

Item 23b Film 3311 1/26/62 mb

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda (Rural)

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

U. S. Naval Hospital

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

HAZEL

RALSTON

STRUBLE

APRIL

19,

1962

5. SEX

6. COLOR OR RACE

7. MARRIED ☒ NEVER MARRIED ☐

8. DATE OF BIRTH

9. AGE (In years last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Female

Caucasian

WIDOWED ☐ DIVORCED ☐

July 22, 1892

69

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State or foreign country)

Oregon

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Lonner Owen RALSTON

Ada K. JOHNS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

(b)

DUE TO

(c)

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).

INTERVAL BETWEEN ONSET AND DEATH

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I. or Part I. of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m. p.m.
1920d. INJURY OCCURRED
While Not While
at work at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that ☒ (this hospital) attended the deceased from March 19, 1962 to April 19, 1962, that ☒ (we) last saw the deceased alive on April 19, 1962, and that death occurred at 3:45 AM from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

PAUL G. LINEWEAVER LCDR MC USN U. S. Naval Hospital, Bethesda, Maryland

ATTENDING PHYS.

MED. DIRECTOR ☐STAFF PHYS. ☒

22b. DATE SIGNED

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town or county)

(State)

Burial

April 23, 1962

Arlington National

Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE

Bethesda, Md.

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Robert A. Humphrey Funeral Home 7557 Wisc. Ave

DATE APR 23 '62

c. 1008 S. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Poolesville</u>		c. LENGTH OF STAY IN 1b <u>life</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Poolesville</u>		d. STREET ADDRESS <u>md-R-109</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>md. R-109 Poolesville</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Morris Benj Summerville</u>				4. DATE OF DEATH Month <u>Apr</u> Day <u>10</u> Year <u>1962</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-23-96</u>	
9. AGE (in years last birthday) <u>65 yrs</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labours</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>				13. FATHER'S NAME <u>William Summerville</u>			
14. MOTHER'S MAIDEN NAME <u>Lethia Plummer</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Walter Summerville - Poolesville md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>420</u> DUE TO (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22b. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Poolesville, Cem.</u>			
22d. DATE THEREOF <u>4-15-62</u>				22e. LOCATION (City, town, or country) (State) <u>Poolesville, Md</u>			
23. FUNERAL DIRECTOR <u>R. L. Snowden</u>				24a. REC'D BY REGISTRAR DATE <u>APR 23 '62</u>			
ADDRESS <u>Rockville Md</u>				24b. REGISTRAR'S SIGNATURE <u>C. S. Kenna</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04842

CERTIFICATE OF DEATH

04841

1. PLACE OF DEATH

a. COUNTY

MONTGOMERY

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Suburban

Middle

East

West

3. NAME OF DECEASED (Type or print)

EDWIN

SWINGLE

4. DATE OF DEATH

APRIL

Day

Year

5. SEX

Male

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

Lawyer

Wash. D.C.

U.S.A.

13. FATHER'S NAME

Morgan Swingle

14. MOTHER'S MAIDEN NAME

Sarah E. Hodgkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT

Son A. Swingle Same as above.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

4-20-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)

CONGESTIVE HEART FAILURE

CORONARY OCCLUSION

ARTERIO SCLEROTIC HEART DISEASE

INTERVAL BETWEEN ONSET AND DEATH

1 + 1/2 hr

2 days

11 + 1/2 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

EMPHYSEMA

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner.)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from. 4/24/1962 to 4/30/1962, that (I) (we) last saw the deceased alive on 4/30 1962, and that death occurred at 4:35 A.M. from the causes and on the date stated above.

22a. SIGNATURE

Charles J. Savarese Jr.

ATTENDING PHYS. ☒

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

4-30-62

22c. PHYSICIAN'S NAME (Type)

Charles J. Savarese Jr.

22d. ADDRESS

4890 Battery Lane, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

5/4/62

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY

Ft. Lincoln Cemetery

23d. LOCATION (City, town or county)

Prince George Co. Md.

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Robert A. Pumphrey, Bethesda, Maryland

DATE

MAY 4 '62

Charles J. Savarese

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 3 and return it to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04843
CERTIFICATE OF DEATH
04842

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>3 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8228 New Hampshire Avenue</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8228 New Hampshire Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Birdie</u> Middle <u>Virginia</u> Last <u>Taylor</u>		4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>1962</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month <u>May</u> Day <u>23</u> Year <u>1895</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Stafford, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Power</u>		14. MOTHER'S MAIDEN NAME <u>Sadie Winkler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Bonnie Beagle 544 Univ. Blvd., F., S.S., Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 33 IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arteriosclerotic Vascular Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Immediate</u> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (<u>Not</u> hospital) attended the deceased from <u>Jan 1959</u> to <u>April 62</u> , that (I) (<u>was</u>) last saw the deceased alive on <u>April 28, 1962</u> , and that death occurred at <u>11:00 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Bernard A. Fitzgerald</u>		22b. DATE SIGNED <u>4-30-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Bernard Fitzgerald</u>		22d. ADDRESS <u>217 University Blvd., F., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>5-2-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Andrews Chapel Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Stafford, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Zeller</u> Address <u>434 Georgia Ave.</u> Berneer P. Pembrey, Inc. Silver Spring, Maryland		25a. REC'D BY REGISTRAR <u>MAY 2 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles S. Fiance</u>			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

Item 3 Film 3312 5/1/62

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04843

1. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Silver Spring
c. LENGTH OF STAY IN b. 3 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8101 Eastern Ave - Apt 514

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE md b. COUNTY Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
d. STREET ADDRESS 8101 Eastern Ave - Apt 514
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Esther Ruth Tepper
First Middle Last
4. DATE OF DEATH Apr 25 1962
Month Day Year

5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 10-5-1914
WIDOWED ☐ DIVORCED ☐ 47 yrs.
9. AGE (In years last birthday) 47 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 10b. KIND OF BUSINESS OR INDUSTRY - 11. BIRTHPLACE (State or foreign country) NEBRASKA 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Carroll Jacobson 14. MOTHER'S MAIDEN NAME LENA BATES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. 599-36-9136 17. INFORMANT Julian Tepper (son) Address Stem 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
501X DUE TO Pneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Impacted mucus in Bronchial Tree
(c)

INTERVAL BETWEEN ONSET AND DEATH Found in bed

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

SIGNATURE Frank J. Broscham M.D. DATE SIGNED Apr 25-62

EXAMINER'S NAME (Type) FRANK J. Broscham Address (Street, city, town, or county)

22a. BURIAL, CREMATION, or REMOVAL (Specify) BURIAL 22b. DATE THEREOF 4/27/62 22c. NAME OF CEMETERY OR CREMATORY NATK. MEM. PARK 22d. LOCATION (City, town, or country) (State) FALLS CHURCH, VA.

23. FUNERAL DIRECTOR Greedy Funeral Home ADDRESS 4217-9th Ave 24a. REC'D BY REGISTRAR APR 27 '62 24b. REGISTRAR'S SIGNATURE Charles E. Harris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be completed by the hospital or attending physician, and completely filled in by the funeral director. Page 2 may be completed by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01845

01844

1. PLACE OF DEATH
a. COUNTY **MONTGOMERY**
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Wheaton, Md**
c. LENGTH OF STAY in hospital (if not in hospital, give street address) **2 WEEKS**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Wheaton Nursing Home**

2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
a. STATE **Md.**
b. COUNTY **MONTGOMERY**
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **SILVER SPRING**
d. STREET ADDRESS **115 SOUTHWOOD AVE**
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
First **FRANCES** Middle **TREGIDA** Last **GA**

4. DATE OF DEATH
Month **4** Day **26** Year **1962**

5. SEX **F**

6. COLOR OR RACE **W**

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH
Month **7** Day **24** Year **1874**

9. AGE (In years last birthday) **87**
IF UNDER 1 YEAR: Months **8** Days **7**
IF UNDER 24 HRS.: Hours **8** Min. **7**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housewife**
10b. KIND OF BUSINESS OR INDUSTRY **England**
11. BIRTHPLACE (County & State, or foreign country) **U.S.**
12. CITIZEN OF WHAT COUNTRY? **U.S.**

13. FATHER'S NAME **ROBERT SUTCLIFFE**
14. MOTHER'S MAIDEN NAME **ZILLAH GREENWOOD**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **NO**
16. SOCIAL SECURITY NO. **NO**
17. INFORMANT **ZILLAH GREENWOOD** Address **115 SOUTHWOOD AVE**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) **Congestive heart failure**
DUE TO (b) **Generalized metastases from Sarcoma of joint.**
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) **of joint.**
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) **NO**
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) **NO**

20c. TIME OF INJURY Month, Day, Year **3/5/62**
Hour a.m. **19** p.m. **19**
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **4/26/62**
20f. (City or town) **Silver Spring, Md.** (County) **Montgomery** (State) **Md.**

21. I certify that (I) (this hospital) attended the deceased from **3/5/62** to **4/26/62**, that (I) (we) last saw the deceased alive on **4/17/62**, and that death occurred at **5:45 PM**, from the causes and on the date stated above.

22a. SIGNATURE **Aldo Vacca**
22b. DATE SIGNED **4-26-62**
22c. PHYSICIAN'S NAME (Type) **Aldo VACCA**
22d. ADDRESS **1429 University Blvd, W. Silver Spr, Md**

23a. BURIAL, CREMATION, or other disposal **Cremation**
23b. DATE THEREOF **April 27, 1962**
23c. NAME OF CEMETERY OR CREMATORY **Lee Crematory Wash, D.C.**
23d. LOCATION (City, town or county) **Wash, D.C.** (State) **D.C.**

24. FUNERAL DIRECTOR'S SIGNATURE **LEE Funeral Home Wash.** ADDRESS **Wash.**
25a. RECORD BY REGISTRAR **APR 30 '62**
25b. REGISTRAR'S SIGNATURE **Arthur L. Hanna**



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the reason in pencil in item 1B. Give Pages 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04845

04845

1. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Faithursburg
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Besthaven Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE MD b. COUNTY Adelphi Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi
d. STREET ADDRESS 1021 South Barton St.

3. NAME OF DECEASED (Type or print) Thomas Trussell
4. DATE OF DEATH Apr 30 1962

5. SEX male 6. COLOR OR RACE white 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH Dec 30, 1906
9. AGE (In years last birthday) 55 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer 10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Martinsburg, W. Virginia, U. S. 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Emilland Trussell 14. MOTHER'S MAIDEN NAME Loraine W. Trussell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Loraine W. Trussell Address as no 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Respiratory Failure
DUE TO Syphilis, Constitutional
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 5-8-62 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Brosehart M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) FRANK J. Brosehart ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 4-30-62
Address (Street, city, town, or county) (State)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 5-8-62 22c. NAME OF CEMETERY OR CREMATORY Rose Dale 22d. LOCATION (City, town, or county) (State) Martinsburg - W. Va

23. FUNERAL DIRECTOR Emil C. Gartner, Faithursburg, Md. ADDRESS 24a. REC'D BY REGISTRAR Walter S. Kinner 24b. REGISTRAR'S SIGNATURE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 is to be filed by the hospital or attending physician. Page 2 is to be filed by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04847											
04846											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in lb <u>184 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>Clompia</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>4703 Opal Street</u> d. STREET ADDRESS <u>54X 3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type and print) <u>Minnie</u> (No middle name) <u>Unglaub</u> First Middle Last				4. DATE OF DEATH <u>April 13,</u> 19 <u>62</u> Month Day Year				5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>20 November 1934</u> 9. AGE (in years last birthday) <u>27</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Michigan</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Robert W. Jeffrey</u> 14. MOTHER'S MAIDEN NAME <u>Nina Stewart</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>386-32-452</u> 16. SOCIAL SECURITY NO <u>386-32-452</u> 17. INFORMANT <u>The Medical Record, The Clinic Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>173X</u> DUE TO Conditions, if any, <u>Metastatic Choriocarcinoma</u> gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (X) (this hospital) attended the deceased from <u>Oct. 11, 1961</u> to <u>April 13, 1962</u> , that (X) (we) last saw the deceased alive on <u>April 13, 1962</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Stanley G. Korenman</u> 22c. PHYSICIAN'S NAME (Type) <u>Stanley G. Korenman</u> 22b. DATE SIGNED <u>Ex April 13, 1962</u> 22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>4/18/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>1400 Phoebe St NW Washington DC</u> 23d. LOCATION (City, town or county) (State) <u>OLYMPIA WASH.</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co.</u> 25a. REC'D BY REGISTRAR <u>APR 17 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
04843		Item 250, Film 0312-572/62 iwk		04847					
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>35 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>1104 Parrish Drive</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>Alice</u> Last <u>Van Pelt</u>		4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1962</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10 December 1913</u>		9. AGE (In years last birthday) <u>48</u> yrs IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail</u>		11. BIRTHPLACE (State or foreign country) <u>Minnesota</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jule Pagnac</u>				14. MOTHER'S MAIDEN NAME <u>Georgia Elfrink</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>502-10-4583</u>		17. INFORMANT <u>The Medical Record, Address</u> <u>The Clinical Center, Bethesda 14, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> <u>204.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Myelogenous Leukemia</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>10 months</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (if this hospital) attended the deceased from <u>March 20, 1962</u> to <u>April 24, 1962</u> , that (if we) last saw the deceased alive on <u>April 24, 1962</u> , and that death occurred at <u>10:35</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Robert H. Levin</u>		M.D.		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>April 24, 1962</u>			
22c. PHYSICIAN'S NAME (Type) <u>Robert H. Levin, M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial - 1-17-62 / 11/17/62</u>		23b. DATE THEREOF <u>11/17/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		23d. LOCATION (City, town, or county) (State) <u>Greenwood, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wheeler Funeral Home</u>		111 ADDRESS <u>Long Ave.</u> <u>Rockville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 27 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Carlton S. Thomas</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

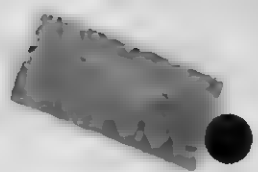
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

64849

CERTIFICATE OF DEATH

04848

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY in 1b 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hvattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		d. STREET ADDRESS 1412 Kanawha Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Marine Wright Veirs		4. DATE OF DEATH April 13, 1962		5. SEX Female	
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/27/13	
9. AGE (In years last birthday) 48 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Elmo L. Wright	
14. MOTHER'S MAIDEN NAME Gladys Mattes		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO None	
17. INFORMANT Mother, Gladys Wright		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from... 4-31... 1962 to... 4-13... 1962, that (I) (we) last saw the deceased alive on... 4-12... 1962 and that death occurred at... 2 M, from the causes and on the date stated above.		22a. SIGNATURE J. W. Peabody, Jr., M.D.		22b. DATE SIGNED 4-13-62	
22c. PHYSICIAN'S NAME (Type) J. W. Peabody, Jr., M.D.		22d. ADDRESS 1150 Conn. Ave N.W. Wash. D.C.		22e. REGISTRAR'S SIGNATURE	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 4/17/62		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	
23d. LOCATION (City, town or county) Suitland, Maryland		23e. REC'D BY REGISTRAR DATE		23f. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04850 CERTIFICATE OF DEATH 04849

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dawsonsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Matthews Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> d. STREET ADDRESS <u>4923 Chevy Chase Blvd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>Reach</u> Last <u>Wade</u> 4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1962</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Aug. 13, 1870</u> 9. AGE (in years, IF UNDER 1 YEAR last birthday) Months <u>91</u> Days <u>8</u> Hours <u>12</u> IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Unknown</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>W. C. Murphy III-grandson-same 2d</u> Address <u>-----</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic-Cardiovascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>-----</u> (c) <u>-----</u> DUE TO (e), stating the underlying cause last. (c) <u>-----</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-----</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>-----</u> p.m. <u>-----</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u> 20f. (City or town) <u>-----</u> (County) <u>-----</u> (State) <u>-----</u>		21. I certify that (I) (this hospital) attended the deceased from <u>30 Jan 1961</u> to <u>25 Apr 1962</u> , that (I) (we) last saw the deceased alive on <u>24 Apr 1962</u> , and that death occurred at <u>5:46 AM</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>Gordon M. Smith</u> M.D. <u>-----</u> 22b. DATE SIGNED <u>25 Apr 62</u> 22c. PHYSICIAN'S NAME (Type) <u>Gordon M. Smith MD</u> 22d. ADDRESS <u>Princeton, Ill.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> 23b. DATE THEREOF <u>4/25/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u> 23d. LOCATION (City, town or county) <u>Suitland, Maryland</u> (State) <u>-----</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u> ADDRESS <u>-----</u> 25a. REC'D BY <u>APR 30 1962</u> 25b. REC'D BY <u>Arthur L. Kneiss</u>	

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04851 CERTIFICATE OF DEATH 04850

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (rural) c. LENGTH OF STAY IN b. 20 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Naval Hospital, Bethesda, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D.C. b. COUNTY D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C. d. STREET ADDRESS 719 "G" St. S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emmett Middle Doyle Last WALLER		4. DATE OF DEATH Month April Day 13 Year 1962	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-5-84
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Navy		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Emmett Waller		14. MOTHER'S MAIDEN NAME Elizabeth Doyle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 1907-1938		16. SOCIAL SECURITY NO. 578 26 7059	
17. INFORMANT Wife: Mrs. Beaulah M. Waller, Same as #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Purulent meningitis 340.3 DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 24, 1962 , to April 13, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 13, 1962 , and that death occurred at 4:05 AM from the causes and on the date stated above.			
22a. SIGNATURE D. L. Kelly		22b. DATE SIGNED 13 April 1962	
22c. PHYSICIAN'S NAME (Type) D.L. KELLY, LT MC USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVA. (Specify) Burial	23b. DATE THEREOF 17 APRIL 62	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL	23d. LOCATION (City, town or county) (State) ARLINGTON, Va.
24. FUNERAL DIRECTOR'S SIGNATURE R.A. MATTINGLY		25a. REC'D BY REGISTRAR APR 16 '62	
25b. REGISTRAR'S SIGNATURE William L. Howard			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be signed by the attending physician and completely filled in by the funeral director. Page 2 should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04852
04851

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>30 Chevy Chase</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>3911 Parsons Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Bertha B. Walter</u>		4. DATE OF DEATH <u>April 4, 1962</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 16, 1882</u>	
9. AGE (in years if UNDER 1 YEAR; last birthday) <u>79</u> yrs		10. AGE (in years if UNDER 1 YEAR; last birthday) <u>4</u> Months <u>18</u> Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James M. Baer</u>	
14. MOTHER'S MAIDEN NAME <u>Hannah A. Leiby</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. James H. LeVan, daughter same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarction, Left</u> DUE TO <u>Arteriosclerotic C.V. Disease</u> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. <u>7 days</u> DUE TO <u>YRS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>YRS</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from..... to <u>APR 4, 1962</u> , that (I) (we) last saw the deceased alive on <u>APR 4, 1962</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.	
22a. SIGNATURE <u>DeWitt E. DeLauter</u>		22b. DATE SIGNED <u>4-4-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>DEWITT E. DELAUTER</u>		22d. ADDRESS <u>8025 ABERDEEN RD Bethesda Md.</u>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>Burial-transit 4-6-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Charles Evans Cemetery</u>	
23d. LOCATION (City, town or county) (State) <u>Reading, Penna.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>	
25a. REC'D BY REG STRAR <u>APR 6 '62</u>		25b. REGISTRAR'S SIGNATURE <u>John L. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **MARYLAND STATE DEPARTMENT OF HEALTH**
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04853		04852	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4525 Sleaford Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Res. given before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>10506 Weymouth St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Victor Winfield Wanser</u> First Middle Last		4. DATE OF DEATH <u>April 10 1962</u> Month Day Year	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Nov 12, 1896</u> 9. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone installer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Brooklyn N.Y.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Wanser</u> 14. MOTHER'S MAIDEN NAME <u>Harriet De no</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (Yes give year or dates of service) <u>Yes W.W.I 06/10-2646 wife -</u> 16. SOCIAL SECURITY NO. <u>061-10-2646</u> 17. INFORMANT <u>same</u> Gertrude	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Coronary occlusion</u> (c) <u>Atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>seconds</u> <u>seconds</u> <u>15 years</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (his hospital) attended the deceased from <u>Feb 14</u> 19 <u>62</u> <u>March 31</u> 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>March 31</u> 19 <u>62</u> and that death occurred at <u>11:45 AM</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Allen J. O'Neill</u> 22b. DATE SIGNED <u>April 10, 1962</u> 22c. PHYSICIAN'S NAME (Type) <u>Allen J. O'Neill</u> 22d. ADDRESS <u>8601 Old Georgetown Rd, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit 4/11/62</u> 23b. DATE THEREOF <u>4/11/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>New York, New York</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u> 25a. REC'D BY REGISTRAR <u>APR 13 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04854

04853

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN <u>MARYLAND</u> <u>14</u> days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>4525 North Chelsea Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Catherine C. Wells</u>		4. DATE OF DEATH <u>April 25, 1962</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>1/2/80</u>		9. AGE (In years IF UNDER 1 YEAR, IF UNDER 24 HRS. last birthday) <u>82</u> yrs. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington D. C.</u>	
11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Morris Mangan</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Wren</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Catherine Barry, daughter, 7904 Wildwood Dr.</u>		18. ADDRESS <u>Takoma Park, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Advanced AGE</u> PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>no</u>		19. INTERVAL BETWEEN ONSET AND DEATH <u>12 HRS</u> <u>10 YRS</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. [City or town] (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from... <u>Jan 1952</u> to <u>April 1962</u> , that (I) (we) last saw the deceased alive on <u>4/25</u> 19 <u>62</u> and that death occurred at <u>11:30</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>4/26/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. J. J. DONOVAN M.D.</u>		22d. ADDRESS <u>BETHESDA 14 MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/28/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince George Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>APR 30 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneale</u>			

04855

C. H. Feete & Brother, Brunswick, Maryland



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04855

04855

1. PLACE OF DEATH a. COUNTY Montgomery Co.,		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D.C. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kensington Gardens Sanitarium		d. STREET ADDRESS 1223 'M' St. N. W.	
3. NAME OF DECEASED (Type or print) First Middle Last Edith Wilcox		4. DATE OF DEATH Month Day Year APRIL 30th, 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 6, 1877
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9b. AGE (In years last birthday) 85 yrs	
10b. KIND OF BUSINESS OR INDUSTRY HOME-MAKER		11. BIRTHPLACE (County & State, or foreign country) London, England	
13. FATHER'S NAME ??		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. ??	
17. INFORMANT (FRIEND) WASHINGTON, D.C.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Intermittent heart disease 34 yrs DUE TO PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) fracture left femur - Feb '62 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) INTERMITTENT HEART DISEASE 34 yrs	
21. I certify that (I) (this hospital) attended the deceased from... OCT 1, 1972 to APR 30, 1962 , that (I) (we) last saw the deceased alive on... 4/27, 1962 , and that death occurred at... HOME from the causes and on the date stated above.		22a. SIGNATURE Dr. E. Aschenbach	
22c. PHYSICIAN'S NAME (Type) Dr. E. Aschenbach		22b. DATE SIGNED 1841 Col Rd NW	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		23b. DATE THEREOF 5/1/1962	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Suitland Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Hogron Funeral Home		25a. REC'D BY REGISTRAR WASH. 5, D.C.	
25b. REGISTRAR'S SIGNATURE 1300 N. 1st N.W.		25c. DATE MAY 2 '62	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be signed by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7,61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04857

1. PLACE OF DEATH
a. COUNTY MONTGOMERY
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) KENSINGTON
c. LENGTH OF STAY in b. 10 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kensington Gardens SAN

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MARYLAND b. COUNTY FREDERICK
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BRUNSWICK
d. STREET ADDRESS _____
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
First Buttle Middle E Last Williams

4. DATE OF DEATH
Month 4 Day 19 Year 1962

5. SEX F 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 8. DATE OF BIRTH Sept 14, 1912 9. AGE (In years last birthday) 49 yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (County & State, or foreign country) Frederick, Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Kagle 14. MOTHER'S MAIDEN NAME Mary Bachley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) _____ 16. SOCIAL SECURITY NO. _____ 17. INFORMANT _____ Address _____

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic melanoma
DUE TO (b) melanoma (on back)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) Diabetes mellitus

INTERVAL BETWEEN ONSET AND DEATH 28 months
28 months

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) _____

20c. TIME OF INJURY
Hour 5 a.m. 19 p.m. 20d. INJURY OCCURRED
While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____

21. I certify that (I) (this hospital) attended the deceased from July 14, 1961, to April 19, 1962, that (I) (was) last saw the deceased alive on April 19, 1962, and that death occurred at 12:30 P from the causes and on the date stated above.

22a. SIGNATURE Aaron H. Trau M.D. 22b. DATE SIGNED April 19 1962
22c. PHYSICIAN'S NAME (Type) _____ 22d. ADDRESS 8237 Georgia Ave Silver Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Buried 23b. DATE THEREOF 4/20/62 23c. NAME OF CEMETERY OR CREMATORY LUTHERAN 23d. LOCATION (City, town or county) BRUNSWICK (State) MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Hume ADDRESS Brunswick 25a. REC'D BY REGISTRAR APR 23 '62 25b. REGISTRAR'S SIGNATURE Arthur L. Hume



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be signed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. It may be signed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. It may be signed by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04858
04857

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ednor</u> c. LENGTH OF STAY IN b. <u>1 WEEK</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Belmont nursing home</u>		2. USUAL RESIDENCE (Where deceased lived, if last before admission) a. STATE <u>Md.</u> b. COUNTY <u>PRINCE GEORGES</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANHAM</u> d. STREET ADDRESS <u>6409 PRINCESS GARDEN</u> e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Marian</u> <u>Hester</u> <u>Williams</u>		4. DATE OF DEATH Month Day Year <u>4</u> <u>27</u> <u>1962</u>	
5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Feb 5 1877</u> 9. AGE (In years, months, days, hours, minutes) <u>85</u> yrs. <u>8</u> mos. <u>18</u> days <u>0</u> hrs. <u>0</u> min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CHARLES COUNTY, Md.</u>	
11. BIRTHPLACE (County & State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Ephraim Williams</u>		14. MOTHER'S MAIDEN NAME <u>Hester Rawlings</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. James A. McElary</u>		Address <u>4545 Conn. Ave. N.W. Washington, D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis</u> DUE TO <u>Abdominal Carcinomatosis</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b) <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Draining obturator (rt) sinus tract</u> INTERVAL BETWEEN ONSET AND DEATH <u>18 mos - 1 yr</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. TIME OF INJURY Hour <u>—</u> e.m. <u>—</u> p.m. <u>—</u> 20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u> 20d. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>4/19</u> to <u>4/27</u> , 19 <u>62</u> that (I) <u>John P. Martin MD</u> last saw the deceased alive on <u>4/26</u> , 19 <u>62</u> and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above.		22a. SIGNATURE <u>John P. Martin MD</u> 22b. DATE SIGNED <u>4/27/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN P. MARTIN MD</u>		22d. ADDRESS <u>SANDY SPRING MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>5/1/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cem.</u> 23d. LOCATION (City, town or county) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Malley's Funeral Home, Inc.</u>		25. REGISTRAR'S SIGNATURE <u>Arthur L. Thane</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

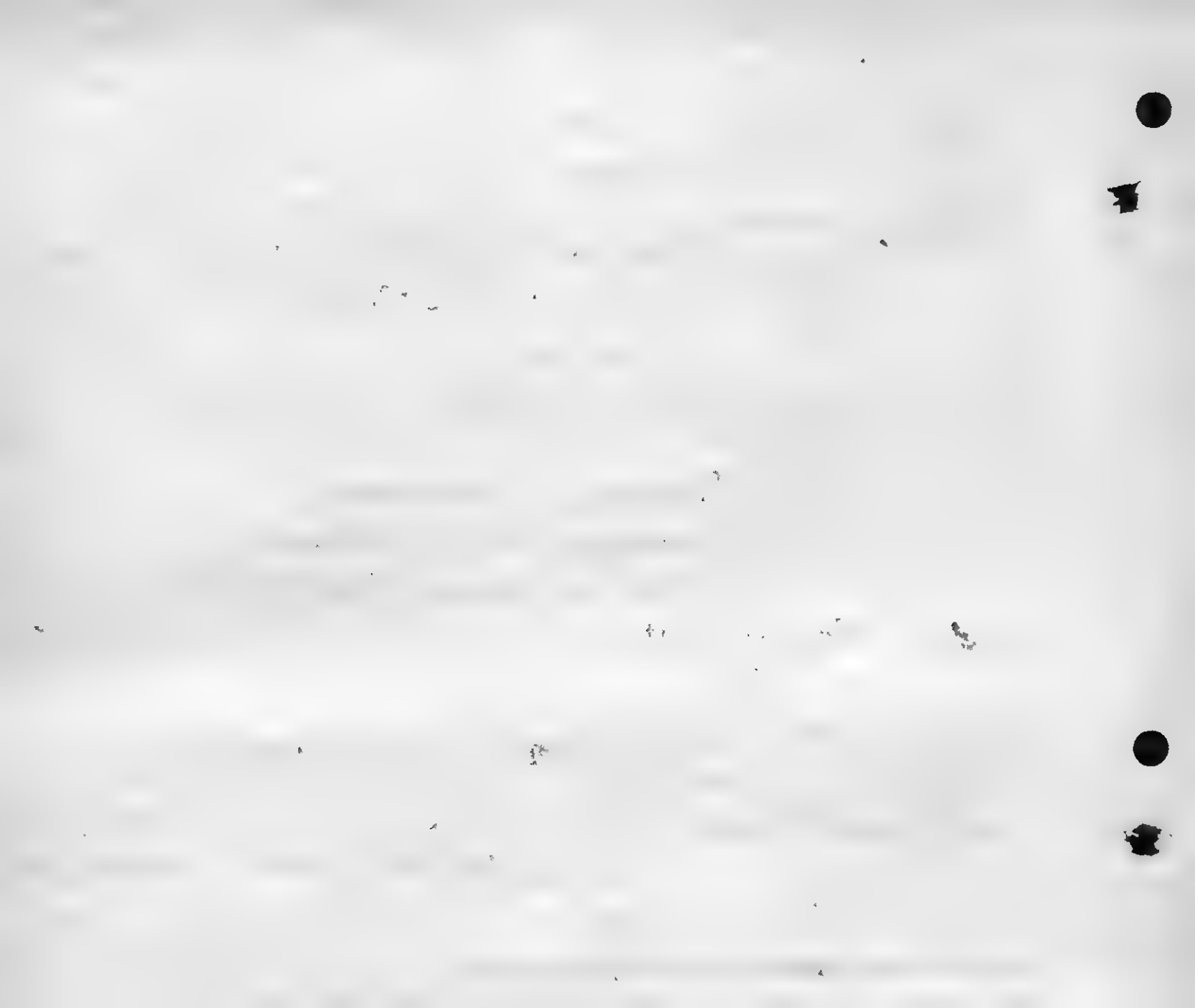
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04859

04858

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) SILVER SPRING 10 MONTHS c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 302 DEARBORN AVE		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 302 DEARBORN AVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RHODA EMMA WITT First Middle Last 4. DATE OF DEATH APRIL 6 1962 Month Day Year		5. SEX FEM 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 22 DEC 1889 9. AGE (In years last birthday) 72 yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS 10b. KIND OF BUSINESS OR INDUSTRY RETIRED (CLOTHING) TENN 11. BIRTHPLACE (County & State, or foreign country) U.S.A. 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME MARION DANIEL WITT 14. MOTHER'S MAIDEN NAME ALICE T. McBEE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NONE 16. SOCIAL SECURITY NO. 41-05-5099 17. INFORMANT MINNIE K. COLLINS 302 DEARBORN AVE S.S.MD.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO Arteriosclerosis Generalized PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) auricular fibrillation Congestive heart failure	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH		20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20b. (City or town) (County) (State)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		21. I certify that (I) (this hospital) attended the deceased from 30 Nov 1959 to 6 Apr 1962 that (I) (we) last saw the deceased alive on 5 Apr 1962 and that death occurred at 8:45 p M, from the causes and on the date stated above.	
22a. SIGNATURE Thomas P. Fogarty 22b. DATE SIGNED 6 Apr 62 22c. PHYSICIAN'S NAME (Type) W.W. Chamberlain 22d. ADDRESS 1011 UNIV. BLVD. E. Silver Spring MD		23a. BIRTHAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 4/7/62 23c. NAME OF CEMETERY OR CREMATORY WHITE PINE CEMETERY 23d. LOCATION (City, town or county) (State) WHITE PINE TENN	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chamberlain ADDRESS SILVER SPRING, MD. 25a. REC'D BY REGISTRAR APR 11 '62 25b. REGISTRAR'S SIGNATURE William S. Thomas			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be completed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7'61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04850

04859

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Congressional Manor Sanitarium 9200 Rockville Pike		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Springfield d. STREET ADDRESS 5613 Lamar Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elizabeth J. Wood		4. DATE OF DEATH April 2, 1962	
5. SEX female		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/20/1884	
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Auditor-Internal Revenue-		11b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
11c. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas B. Wood		14. MOTHER'S MAIDEN NAME Elizabeth J. Relf	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Sarah W. Porter		Address 5613 Lamar Road Washington 16, D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. Arteriosclerosis generalized DUE TO Diabetes mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a)		INTERVAL BETWEEN ONSET AND DEATH 4 days 7 years 7 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town, (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-1-1956 to 4-2-1962 , that (I) (we) last saw the deceased alive on 3-29-1962 and that death occurred at 4 P.M. from the causes and on the date stated above.			
22a. SIGNATURE C. Roger Kuntz, MD		22b. DATE 4-2-62	
22c. PHYSICIAN'S NAME (Type) C. Roger Kuntz, MD		22d. ADDRESS 3701 Conduit W. Wash. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/5/62	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Prince Georges County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Lee S. H. Hinn Co.		25a. REC'D BY REGISTRAR Wash. D.C.	
25b. REGISTRAR'S SIGNATURE Wash. D.C.		DATE	

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. It may be executed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

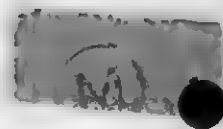
VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04861

04860

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ednor c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Belmont Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if last full on; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 55 Chevy Chase d. STREET ADDRESS 4810 Grantham Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Carl Z Work 4. DATE OF DEATH April 4 19 62 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Dec. 3, 1876 9. AGE (in years, last birthday) 85 yrs. IF UNDER 1 YEAR: Months 4 Days 1 IF UNDER 24 HRS.: Hours 1 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Landscape Gardener 11. BIRTHPLACE (County & State, or foreign country) Illinois 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Work 14. MOTHER'S MAIDEN NAME Laura Crounover 15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes Sp. American 16. SOCIAL SECURITY NO. None 17. INFORMANT Martin H. Work, Son-same above		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 720.00 Congestive Heart Failure DUE TO Arteriosclerotic Hx Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) 1 month several yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I. of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3/18/62 , 1961, to 4/4/62 , that (I) (we) last saw the deceased alive on 3/28/62 , and that death occurred at 6:15 AM , from the causes and on the date stated above.			
22a. SIGNATURE Donald Nelson 22c. PHYSICIAN'S NAME (Type) Donald Nelson		22b. DATE SIGNED 4/4/62 22d. ADDRESS 10620 Georgia Ave Silver Spring, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 4/6/62		23c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery 23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR APR 6 '62 25b. REGISTRAR'S SIGNATURE Charles S. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/10

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04862
CERTIFICATE OF DEATH
04861

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> f. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, D.C.</u> LENGTH OF STAY in lb. <u>47</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash SAN & Hosp</u>		d. STREET ADDRESS <u>35 Shaw Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Ralph Frank Wurtz</u>		4. DATE OF DEATH <u>Apr. 27</u> 19 <u>62</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>7-11-00</u>	9. AGE (If years, IF UNDER 1 YEAR, IF UNDER 24 HRS. last birthday) <u>61</u> yrs. Months <u>6</u> Days <u>16</u> Hours <u>1</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plate Finisher BUR of Engr.</u>		11. BIRTHPLACE (County & State or foreign country) <u>Ill., NOIS</u>	
13. FATHER'S NAME <u>William Henry Wurtz</u>		14. MOTHER'S MAIDEN NAME <u>Louisa Lechow</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> None		16. SOCIAL SECURITY NO. <u>None</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Recurrent myocardial infarctions 6 in 5 yrs</u> DUE TO <u>Myocarditis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1930</u> to <u>27 April</u> 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>24 April</u> 19 <u>62</u> and that death occurred at <u>4:50</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Thomas E. Mattingly, M.D.</u>		22b. DATE SIGNED <u>27 Apr 62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thomas E. Mattingly, M.D.</u>		22d. ADDRESS <u>2200 R.I. Ave NE B.D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-30-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Zappa</u>		25a. REC'D BY REGISTRAR <u>May 2 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Warner F. Pumphrey, Inc., Silver Spring, Maryland</u>		25c. REGISTRAR'S SIGNATURE <u>C. L. H. H. H.</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

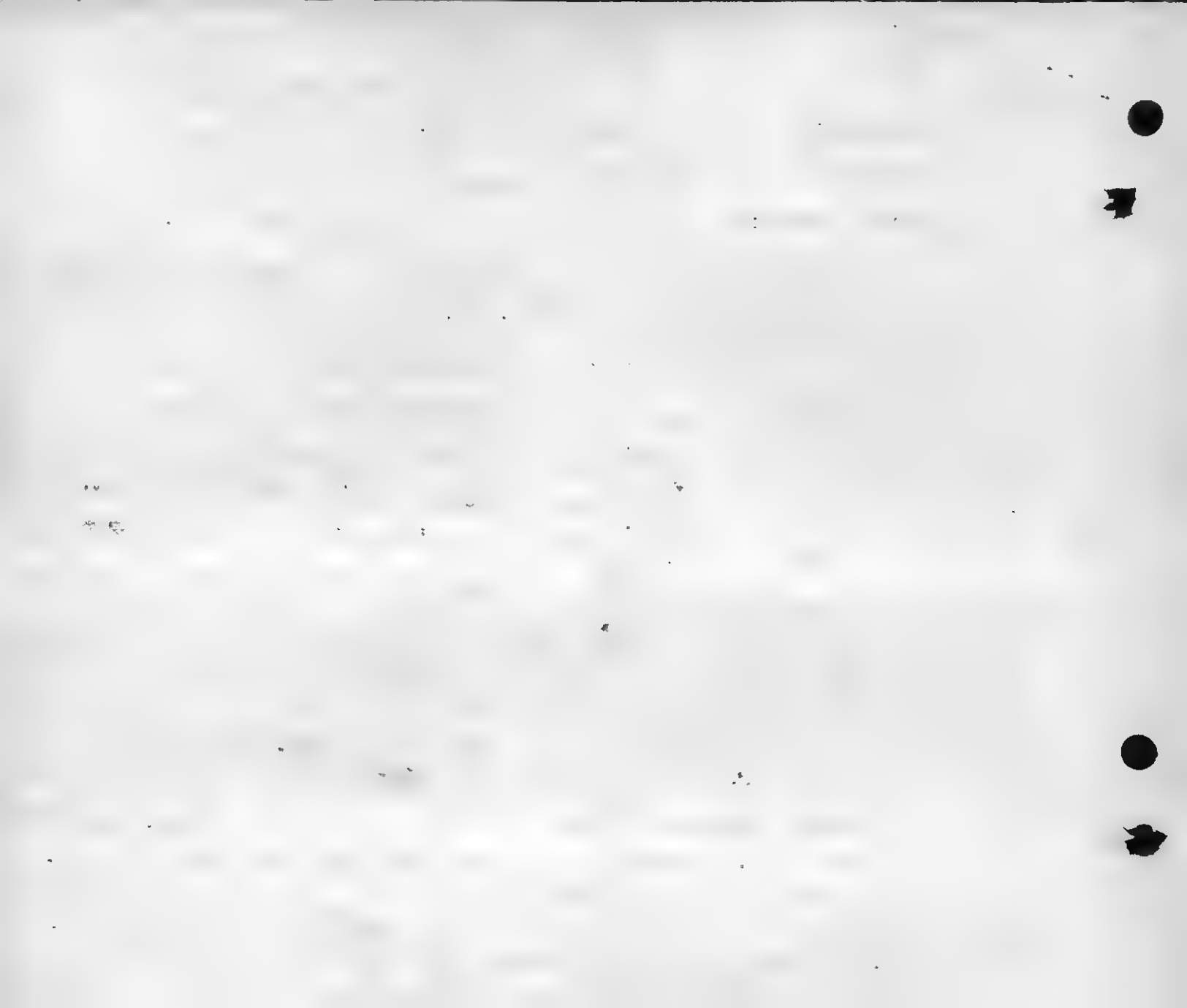
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

94863

04862

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN <u>30 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Resmor Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if installation: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>3339 Nichols Ave. S. E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Susie V. Wynn</u> First Middle Last		4. DATE OF DEATH <u>April 11 1962</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 10, 1892</u> Month Day Year
9. AGE (In years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR Months <u>2</u> Days <u>1</u> IF UNDER 24 HRS Hours <u>1</u> Min. <u>0</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hookkeeper</u> 10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington D. C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13. FATHER'S NAME <u>Samuel Kerby</u> MOTHER'S MAIDEN NAME <u>Marian Watson</u>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		15. SOCIAL SECURITY NO. <u>None</u> 16. INFORMANT <u>Mrs. Birscoe, Sister-Chevy Chase, Md.</u>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CIRCULATORY COLLAPSE</u> Conditions, if any, which gave rise to immediate cause (b) <u>MYOCARDIAL INFARCTION, ACUTE</u> (a), stating the underlying cause last (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>NONE</u>		18. INTERVAL BETWEEN ONSET AND DEATH <u>2 HRS</u> <u>2 HRS</u> <u>10 YRS</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>D. N. A.</u>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____		20c. TIME OF INJURY Month, Day, Year <u>4/12/62</u> Hour a.m. _____ p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that (I) (this hospital) attended the deceased from... <u>4/12/62</u> to... <u>4/11/62</u> that (I) (we) last saw the deceased alive on... <u>4/8/62</u> and that death occurred at... <u>10:15 P.M.</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>Charles J. Savarese MD</u> 22b. DATE SIGNED <u>Apr. 12, 1962</u>		22c. PHYSICIAN'S NAME (Type) <u>CHARLES J. SAVARESE</u>	
22d. ADDRESS <u>4890 Battery Lane, Bethesda, Md.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit</u> 23b. DATE THEREOF <u>4/13/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Greenhill Cemetery</u> 23d. LOCATION (City, town or county) <u>Danville, Virginia</u> (State) _____		24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u> 25a. REC'D BY REGISTRAR <u>APR 17 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be completed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 2 may be filed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04864
Item 9 Film G310 4/11/62 iwk
& 14
04863

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sakima Park</u> c. LENGTH OF STAY IN 1b <u>20 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7416 Holly Avenue</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sakima Park</u> d. STREET ADDRESS <u>7416 Holly Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>-</u> Last <u>Yalsic</u>			4. DATE OF DEATH Month <u>4</u> Day <u>3</u> Year <u>1962</u>		
5. SEX <u>m</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>May 28, 1895</u>		A. E. (in years last birthday) <u>66</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bricklayer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>same</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Syrone, Pa.</u>	
13. FATHER'S NAME <u>Anthony Yalsic</u>			14. MOTHER'S MAIDEN NAME <u>Anna unknown</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>118-07-6363</u>		17. INFORMANT Address <u>Mrs. Barbara Yalsic (same as #2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic Ca</u> 1 <u>54</u> X DUE TO <u>Carcinoma of Rectum</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>2 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a.m.</u> Month, Day, Year <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>60</u> to <u>April 3</u> , 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>April 2</u> , 19 <u>62</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Irving W. Winik</u>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/3/62</u>
22c. PHYSICIAN'S NAME (Type) <u>Irving W. Winik</u>			22d. ADDRESS <u>3900 McKinley St. N.W.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>April 4, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	
23d. LOCATION (City, town or county) <u>Prince George Co. Md.</u>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>			ADDRESS <u>254 Carroll St NW Wash DC</u>		
25a. REC'D BY REGISTRAR <u>APR 5 '62</u>			25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>		

(M)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be filed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04865						04864					
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN It MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase d. STREET ADDRESS 9 Magnolia Parkway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) IDA PERRY YOUNG						4. DATE OF DEATH April 22 1962					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-6-1873		9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home						10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Proby Young						14. MOTHER'S MAIDEN NAME Ida Perry					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) -				16. SOCIAL SECURITY NO. None		17. INFORMANT Capt. John B. Brown, 7825 Aberdeen Rd. Bethesda, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Kidney failure & uremia 434.1 DUE TO (b) Fracture left hip (intercapular) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) Congestive heart failure & general arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture left hip (intercapular) 17 days											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on stairs					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home			20f. (City or town) (County) (State) Chevy Chase Montgomery Md.		
21. I certify that (I) (this hospital) attended the deceased from April 6, 1962 to April 22, 1962 , that (I) (the) last saw the deceased alive on April 20, 1962 , and that death occurred at 5:10 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Gilbert B. Rude M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED April 23, 62		
22c. PHYSICIAN'S NAME (Type) Gilbert B Rude						22d. ADDRESS 3900 Military rd. N.W. DC.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 4-25-1962			23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery			23d. LOCATION (City, town or county) (State) Washington, D. C.		
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Hawler's Son						ADDRESS 1756 Pa. Ave., Wash. DC.			25a. REC'D BY REGISTRAR APR 25 62		
						25b. REGISTRAR'S SIGNATURE Charles S. ...					

1981

2075

Montgomery

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